VA Maryland Health Care System/ University of Maryland School of Medicine Psychology Internship Consortium

2016-2017 Brochure

The VAMHCS/UM SOM Psychology Internship Consortium

is accredited by the

American Psychological Association

The next site visit will be during the 2016 training year.

Questions related to the program's accreditation status should be directed to the
American Psychological Association Commission on Accreditation:
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TABLE OF CONTENTS

INTRODUCTION

Clinical Settings

VA Maryland Health Care System

The Veterans Affairs Maryland Health Care System (VAMHCS) is a dynamic and progressive health care organization dedicated to providing quality, compassionate and accessible care and service to Maryland's Veterans. The Baltimore and Perry Point VA Medical Centers, in addition to the Loch Raven VA Community Living & Rehabilitation Center and six community based outpatient clinics, all work together to form this comprehensive health care delivery system. Nationally recognized for its outstanding patient safety and state-of-the-art technology, the VAMHCS is proud of its reputation as a leader in Veterans' health care, research and education.

Statistics for FY 2014 show that the VAMHCS recorded almost 600,000 separate outpatient encounters, with over 52,000 unique patients. The Baltimore VA Medical Center recorded almost 400,000 separate patient encounters with over 45,000 unique patients, and the Perry Point Medical Center recorded almost 100,000 and over 13,000 unique patients for the same time period. The sheer volume of patients treated across the variety of clinics ensures that interns are exposed to a diversity of patient demographics, encounter a spectrum of degrees of complexity in presenting mental health and medical problems, and experience a variety of patient problems with enough frequency to establish good baseline knowledge of a variety of psychological phenomena.

Baltimore VA Medical Center: The Baltimore VA Medical Center is located in a vibrant city neighborhood on the campus of the University of Maryland at Baltimore (UMB) and is within walking distance of Oriole Park at Camden Yards, M&T Bank Stadium, Lexington Market and the Inner Harbor. The Baltimore VA Medical Center is the acute medical and surgical care facility for the VAMHCS and offers a full range of inpatient, outpatient and primary care services, as well as a number of specialized programs and services, including integrated mental health in primary care programs, a women Veterans evaluation and treatment program, medical psychology and treatment for chronic pain, inpatient and outpatient mental health care services, a residential trauma recovery program, and an intensive outpatient substance abuse detoxification and treatment program. Three blocks from the medical center, the Baltimore Annex offers outpatient mental health programming in the following specialty areas: trauma recovery, neuropsychology, and psychosocial rehabilitation and recovery.

Perry Point VA Medical Center: The Perry Point VA Medical Center is located about 45 minutes north of Baltimore on a beautiful campus of approximately 400 acres on the banks of the Susquehanna River and the Chesapeake Bay. It provides a broad range of inpatient, outpatient, and primary care services and is a leader in providing comprehensive mental health care to Maryland's Veterans. The medical center offers long and short-term inpatient and outpatient mental health care, including the following specialized treatment programs:

- Mental Health Intensive Case Management
- Psychosocial Rehabilitation and Recovery Center
- Health Improvement Program
- Family Intervention Team
- Outpatient Trauma & Post Traumatic Stress Disorder Program
- Substance Abuse Residential Rehabilitation Treatment
- Domiciliary Residential Rehabilitation Treatment (for Homeless Veterans)

Loch Raven Community Living & Rehabilitation Center: The Loch Raven VA Community Living & Rehabilitation Center specializes in providing rehabilitation and post-acute care for patients in the VAMHCS. The center coordinates the delivery of rehabilitation services, including physical therapy, occupational therapy, kinesiotherapy and recreation therapy, to achieve the highest level of recovery and independence for Maryland's

Veterans. The center also provides hospice and nursing home care to Veterans requiring non-acute inpatient care, in addition to offering specialized treatment for patients with Alzheimer's disease and other forms of dementia.

Community Based Outpatient Clinics (CBOCs): Each of our 6 CBOCs provide primary care and limited specialty medical care services. Every CBOC offers Primary Care-Mental Health Integration (PC-MHI), telemental health services, as well as specialty mental health services. Some of the larger CBOCs provide PTSD and Substance Use Disorder services.

- Cambridge VA Outpatient Clinic
- Fort Howard VA Outpatient Clinic
- Fort Meade VA Outpatient Clinic
- Glen Burnie VA Outpatient Clinic
- Loch Raven VA Outpatient Clinic
- Pocomoke City VA Outpatient Clinic

University of Maryland Medical Center

Founded in 1823 as the Baltimore Infirmary, the University of Maryland Medical Center (UMMC) is one of the nation's oldest academic medical centers. Located on the west side of downtown Baltimore, the Medical Center is distinguished by discovery-driven tertiary and quaternary care for the entire state and region and innovative, highly specialized clinical programs. The University of Maryland School of Medicine (UM SOM) is part of the University of Maryland Medical System (UMMS), a network of nine area hospitals: University of Maryland Medical Center, UMMC Midtown Campus, Mt. Washington Pediatric Hospital, UM Baltimore Washington Medical Center, UM Charles Regional Medical Center, University of Maryland Rehabilitation and Orthopaedic Institute, UM St. Joseph Medical Center, UM Shore Regional Health, and UM Upper Chesapeake Health.

Patients admitted to the UMMC benefit from the talent and experience of the very finest physicians, nurses, researchers and other health care providers. Here, health care professionals from many disciplines work together as a team to cure illness, conquer disease, and assure the needed support for patient and family alike. All of the medical center's physicians are faculty members at the School of Medicine, the nation's fifth oldest and first public medical school and a recognized leader in biomedical research and medical education.

Clinical and Research Innovation

VAMHCS/UM SOM Consortium interns are exposed to clinical and research experiences within a number of centers at the VAMHCS and UMB. Having several robust research programs enhances the ability to provide state-of-the-art medical techniques and treatments while providing high quality scientist-practitioner training to Consortium interns.

The VAMHCS is home to the following specialized clinical and research centers:

1. *Epilepsy Center of Excellence* – focus on improving the health and well-being of Veteran patients with epilepsy and other seizure disorders through the integration of clinical care, outreach, research, and education
2. *Geriatric Research, Education and Clinical Center* (GRECC)- focus on promoting health and enablement models in older Veterans living with disability
3. *Maryland Exercise and Robotics Center of Excellence (MERCE)*- focus on rehabilitation of individuals with chronic deficits as a result of stroke with additional developing programs in Parkinson's Disease, Multiple Sclerosis, Chronic Pain, and Traumatic Brain Injury
4. *Mental Illness Research, Education and Clinical Center* – focus on supporting and enhancing the recovery and community functioning of Veterans with serious mental illness through research, education, clinical training and consultation

5. *Multiple Sclerosis (MS) Center of Excellence – East (MSCoE East)* **–** focus on understanding multiple sclerosis, its impact on Veterans, and effective treatments to help manage multiple sclerosis symptoms

UM SOM boasts several research centers:

1. *Division of Services Research (DSR)* – focus on conducting research that improves the quality and outcomes of care for persons suffering from mental disorders
2. *Center for School Mental Health (CSMH)* – focus on strengthening policies and programs in school mental health by advancing evidence-based care in schools and collaborating at local, state, national, and international levels to advance research, training, policy, and practice in school mental health
3. *Maryland Psychiatric Research Center (MPRC)*- focus on providing treatment to patients with schizophrenia and related disorders, educating professionals and consumers about schizophrenia, and conducting basic and translational research into the manifestations, causes, and treatment of schizophrenia
4. *Center for Behavioral Treatment of Schizophrenia (CBTS)* – focus on developing and evaluating behavioral treatments for schizophrenia and the integration of psychosocial and pharmacological treatments
5. *Taghi Modarressi Center for Infant Studies (CIS)* – focus on providing multidisciplinary care in an outpatient setting for children ages 0-6 with emotional and behavioral concerns and studying the relationship between social competence and behavior problems, parenting factors and parenting stress, and routines and other related behaviors in preschool children
6. *General Clinical Research Center* - cornerstone for clinical research within the University of Maryland by providing supports the full spectrum of patient-oriented research
7. *UM School of Medicine Clinical and Translational Sciences Institute* - focus on providing a portal for high-quality cost-effective resources and services for clinical and translational researchers that will support clinical research, informatics, biostatistics, genomics and other core services, community engagement ethics and regulatory science, pilot projects and the development of novel technologies fully integrated through a shared organizational structure and wired by informatics
8. *UM Child and Adolescent Mental Health Innovations Center* – focus on developing and advancing evidence-based interventions for community mental health treatment, models for integration of behavioral health services, and multi-disciplinary training to improve services for underserved young people

PROGRAM OVERVIEW

Training Model and Program Philosophy

The VAMHCS/UM SOM Psychology Internship Consortium adheres to the scientist-practitioner approach to training. The Consortium applies this model by grounding the content and process of training in research, with the purpose of developing well-rounded and competent psychologists. Studies of methods of training have consistently demonstrated processes for effectively impacting trainee behavior, which include modeling desired behaviors, providing opportunities to practice those behaviors in a supervised environment, and giving specific feedback on progress toward the desired behavior. Utilizing this approach, within a developmental framework of continuous reciprocal trainee feedback and program evaluation, the Consortium is able to meet the individualized goals of each trainee while enhancing progress toward core training competencies.

Our program believes that evidence-based practice for the psychological treatment of mental illness and other conditions are crucial for the effective care of patients. We require our interns to actively engage in research that supports their ability to: 1.) identify and clearly describe the disorders and conditions presented by patients, 2.)

select or create reliable and valid outcome measures that are sensitive to changes in patients' disorders or conditions, and 3.) identify and successfully administer treatments to improve these disorders or conditions.

As one of the few internship training programs recognized by the Academy of Psychological Clinical Science (APCS), the Consortium is particularly interested in applicants from graduate programs that place an equally strong emphasis on scientific study and broad clinical training. For the scientist component, it is expected that applicants have a combination of peer-reviewed publications and professional presentations that clearly demonstrate their skills as a psychological scientist. For the practitioner component, it is expected that applicants have solid foundational training and skills across a broad range of clinical populations, evidence-based practices, and in a wide range of objective psychological assessments. Each of these requisite skills must be clearly addressed in the application and in letters of recommendation.

While adhering to a scientist-practitioner approach to training that underscores evidence-based practice, the Consortium aims to train and refine skills in core competency domains (e.g., assessment, treatment, and consultation) with the ultimate goal of facilitating the development of interns from trainees to independent psychologists. As an illustration, specific training in assessment or treatment for a particular presenting problem will be grounded in research, clinical practice guidelines, and expert consensus on that problem. In addition, to foster interns' development as independent scientist-practitioners, didactics and supervision will focus on the skills needed to function independently as a psychologist in a multidisciplinary hospital setting.

To round out existing scientific and clinical skills, extensive efforts are made to tailor the internship training experience to each individual intern's needs and allow a reasonable amount of focused specialization in each intern's area of emphasis. For example, psychology interns attend a weekly didactic seminar that is focused on general training in core competency domains. In addition, interns in specialty tracks attend seminars focused on their area of specialty. Graduates of our program may pursue careers in research or clinical service, but in either case, their training will have prepared them to make a meaningful contribution to the effective care of patients.

Role of the Staff

Consortium staff and supervisors are held to the highest levels of professional and ethical conduct. They are expected to both model these behaviors and promote intern engagement in the following: 1.) ethical and responsible clinical and scientific conduct, 2.) participation in self-regulatory and professional review activities, 3.) commitment to continued professional self-development through participation in training and educational activities, and 4.) activities promoting professional autonomy, such as active involvement with local, state, and national organizations, legislative efforts, and licensure activities.

Role of the Intern

Consortium interns are expected to assume the role of professional psychologist within their training assignments. This role requires awareness of and adherence to the highest principles of professional ethics, conduct, and competence, as well as a sincere interest in the welfare of clients. Interns have the opportunity to learn new clinical skills and techniques from their supervisors and other staff, as well as the opportunity to improve and modify existing skills. The majority of an intern's time is focused on expansion of clinical competencies. Though interns are expected to conduct themselves professionally, their tasks are primarily learning-oriented. Although there is some variability across training sites and specific clinical rotations, clinical service delivery is considered incidental to the learning process. Interns are not expected to assume the same quantity of duties, workload, or responsibilities normally assigned to the professional psychology staff.

Expectations

Interns are expected to be involved in their clinical training assignments to the benefit of the VAMHCS and UMB health care delivery systems and their own learning experiences. They are expected to participate in training meetings and to present material in case presentations, seminars, and other formats during the year, and to engage willingly in dialogue with staff in the service of professional training and development. Interns are expected to adhere to the ethical guidelines established for psychologists by the American Psychological Association and to the policies and procedures of their host institution and clinics.

Training Goals and Objectives

Along with adherence to a scientist-practitioner training model, the Consortium aims to develop and refine skills in seven core competency domains including assessment, treatment, consultation, ethics, diversity, research, and supervision. These core competency domains are deemed essential in facilitating the development of interns from trainees to independent psychologists. From these seven core domains, corresponding goals are generated each with related objectives, outlined below in Table 1: Consortium Goals and Objectives.

Table 1: Consortium Goals and Objectives

GOALS	OBJECTIVES
1. Competence in Professional Conduct, Ethics, and Legal Matters	
	Professional Interpersonal Behavior
	Seeks Consultation/Supervision
	USES POSITIVE COPING STRATEGIES
	PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION
	Efficiency and Time Management
	Knowledge of Ethics and Law
	Administrative Competency
2. Competence in Individual and Cultural Diversity	
	PATIENT RAPPORT
	Sensitivity to Patient Diversity
	Awareness of Own Cultural and Ethnic Background
3. Competence in Theories and Methods of Psychological Diagnosis and Assessment	
	DIAGNOSTIC SKILL
	Psychological Test Selection and Administration
	Psychological Test Interpretation
	ASSESSMENT WRITING SKILLS
	FEEDBACK REGARDING ASSESSMENT
4. Competence in Theories and Methods of Effective Psychotherapeutic Intervention	
	PATIENT RISK MANAGEMENT AND CONFIDENTIALITY
	Case Conceptualization and Treatment Goals
	Therapeutic Interventions
	Effective Use of Emotional Reactions in Therapy
	GROUP THERAPY SKILLS AND PREPARATION
5. Competence in Scholarly Inquiry and Application of Current Scientific Knowledge to Practice	
	SEEKS CURRENT SCIENTIFIC KNOWLEDGE
	DEVELOPS AND IMPLEMENTS RESEARCH PLAN
6. Competence in Professional Consultation	
	Consultation Assessment
	Consultative Guidance
7. Competence in Providing Clinical Supervision	
	Supervisory Skills

Evaluation Procedures

Multiple methods are used to evaluate the Consortium training model and intern progress with the seven identified training goals (Table 2: Consortium Evaluation Plan). Interns are monitored throughout the year, with the aim of facilitating developmental learning and progress toward the seven core competency domains. In addition to measuring progress with these core domains, evaluations include measurement of rotation-specific competencies and open-ended qualitative feedback. A sample evaluation form can be found in Appendix A. It is expected that all competency domains be rated at the intermediate (i.e., routine supervision needed) competency

level or higher at mid-rotation for VA Interns and mid-year for UMB interns. By the end of the rotation or the training year, for VA and UMB interns respectively, the expectation is that 80% of all objectives will be rated at the high intermediate (i.e., competency has been attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant) competency level.

Table 2: Consortium Evaluation Plan

Evaluation Type	Competency	Time Point	Scale
Trainee Core Competency	1. Professional Conduct, Ethics, and Legal Matters 2. Individual and Cultural Diversity 3. Theories and Methods of Psychological Diagnosis and Assessment 4. Theories and Methods of Psychotherapeutic Intervention 5. Scholarly Inquiry and Application of Scientific Knowledge to Practice 6. Competence in Professional Consultation 7. Providing Clinical Supervision	VA: Each rotation Mid and Final (6) UM: Oct, Feb, June (3)	Remedial Entry Level Intermediate (mid) High Intermediate (end) Advanced (autonomous practice) N/A
Trainee Self-Assessment	1. Professional Conduct, Ethics, and Legal Matters 2. Individual and Cultural Diversity 3. Theories and Methods of Psychological Diagnosis and Assessment 4. Theories and Methods of Psychotherapeutic Intervention 5. Scholarly Inquiry and Application of Scientific Knowledge to Practice 6. Competence in Professional Consultation 7. Providing Clinical Supervision	Initial and Final (2)	Remedial Entry Level Intermediate (mid) High Intermediate (end) Advanced (autonomous practice) N/A
Research and Minor Rotations	As Applicable: 1. Professional Conduct, Ethics, and Legal Matters 2. Individual and Cultural Diversity 3. Theories and Methods of Psychological Diagnosis and Assessment 4. Theories and Methods of Psychotherapeutic Intervention 5. Scholarly Inquiry and Application of Scientific Knowledge to Practice 6. Competence in Professional Consultation 7. Providing Clinical Supervision	Mid and Final (2)	Remedial Entry Level Intermediate (mid) High Intermediate (end) Advanced (autonomous practice) N/A
Supervision	1. Supervisory Responsibilities 2. Supervisory Content 3. Supervisory Process 4. Assistance in Professional Development 5. Assistance in Development as Scientist-Practitioner 6. Assistance in Meeting Training Goals 7. Summary Ratings	VA: Each rotation Mid and Final (6) UM: Oct, Feb, June (3) All: Mid and Final Research and Minor	Likert: 1-5 and N/A From Very Ineffective to Very Effective
Year-End	1. Rotation Specific 2. General Questions 3. Seminar 4. Research 5. Overall Experience	End of Year (June)	Qualitative Confidential

If the supervisor perceives that there is a significant deficiency in the intern's competency, the supervisor is to complete the evaluation form at the time the deficiency is identified (even if this occurs outside of the designated evaluation time points) and review it with the intern and the Training Director so that remediation can begin expeditiously. Criteria for successful completion of the training year include completion of all training rotations, completion of six comprehensive integrative assessment reports, completion of a research project, and attendance

in weekly didactic training. The Training Director maintains communication with the interns' graduate programs by providing a letter at the beginning of the year, which describes each intern's training plan, a letter mid-way through the year, which describes each intern's progress with the training plan, and a letter of internship completion at the end of the training year.

Although rotation supervisors provide formal evaluations of intern progress meeting training goals, interns are also asked to provide a self-assessment of these core competency domains at the beginning of the training year and at the end of the training year. Although this self-assessment is not factored into the formal rating of an intern, it is an important aspect of the training program. The self-assessment is discussed individually with the Training Director and is also provided to rotation supervisors as another opportunity to facilitate individualized training and core competency development.

During each evaluation time point, interns provide evaluations of rotation supervisors within the following domains: supervisory responsibilities, supervisory content, supervisory process, assistance in professional development, assistance in development as a scientist-practitioner, and assistance in meeting training goals. Interns are encouraged to use these evaluations as an additional opportunity to discuss how supervisors can assist with meeting training goals and expectations. The Training Director also receives a copy of these evaluations.

Last, interns provide confidential qualitative program-level feedback to the Training Director at the end of the training year. Interns are queried on the following experiences: clinical rotations, general strengths and weaknesses of the Consortium, didactic training, and the research requirement. Once de-identified and aggregated, this feedback is shared with the Training Committee to inform program improvements.

Clinical Supervision and Support

Interns receive a minimum of four hours per week of supervision, at least two hours of which are individual, face-to-face supervision with a licensed psychologist. Supervisors are readily available to respond to interns' questions and provide impromptu guidance. When an intern's primary supervisor is on leave, back-up coverage is clearly delineated. At the beginning of a training rotation, the supervisor and intern jointly assess the intern's training needs and establish individualized training goals. Over the course of the rotation, the intern is expected to become more independent in his or her activities, consistent with the Consortium's developmental approach to training. As this process of attaining graduated levels of responsibility unfolds, the supervision becomes less directive and more consultative.

Staff psychologists with appropriate clinical privileges provide primary supervision to interns. Credentialed clinicians from allied professions and non-staff psychology consultants provide supplemental training expertise. There are opportunities for additional supervisory consultation with psychologists working outside the intern's normal assignment area as well. Consortium faculty use various modes and models of supervision in the training of interns, including co-therapy, analysis of audiotaped or videotaped sessions, supervisor "shadowing," and "junior colleague." In all cases, interns work closely with supervisors initially, and then gradually function more independently as their skills develop. Responsibility for ensuring adequacy of supervision rests with the Consortium Training Committee, under the leadership of the Psychology Training Program Director.

The Consortium Training Committee believes that evidence-based best practice guidelines for the psychological treatment of mental illness and other conditions are crucial to the effective care of patients. Consortium supervisors are trained in a number of theoretical orientations and value the use of scientific literature to inform clinical practice. The Consortium Training Committee also believes that evidence-based practice requires that psychologists maintain the skills to interpret relevant research findings and treatment developments, as well as the skills to contribute to this expanding knowledge base.

In addition to formal supervisory relationships, Consortium interns may take advantage of a mentorship program that pairs interns with a non-supervisor mentor to assist with growth in professional development. The nature of this relationship can be defined and structured as necessary for each trainee. Areas that have been of focus include defining one's professional identity, postdoctoral fellowship and job applications/interviewing strategies, assistance with grant-writing and publications, and managing grievances. Additionally, each internship cohort is offered the opportunity to participate in a consultation group facilitated by a psychologist in a non-supervisory role. The group typically meets twice per month to provide support and encouragement regarding dissertation

progress, supervision, adjustment to internship, living in a new city, and professional development. Finally, the Training Committee meets once per month with the internship class to discuss current concerns as well as topics related to professional development.

Training Term

The internship training year is for a term of 12-months beginning on or about June 30th. Interns must work at least 2,080 hours, with most interns working an average of 40-50 hours per week. This length is consistent with the majority of other psychology internships in the United States and allows interns to meet state licensure requirements. Interns spend approximately 24 hours per week engaged in clinical activities at their major rotation/clinic. The remaining 16 hours include minor clinical rotations (up to 6 hours per week), a research minor rotation (up to 6 hours per week), seminars (3 or more hours per week), and administrative activities.

Stipend and Benefits

The current intern stipend is $26,086. Interns accrue 4 hours bi-weekly of annual leave (13 days total), 4 hours bi-weekly of sick leave (13 days total), 10 federal holidays, and up to 5 professional development days to attend conferences, present papers, or to defend their dissertations. Interns at both the VAMHCS and UMB have access to the health insurance coverage at their respective institutions. There is good public transportation to the Baltimore VA Medical Center and the UMB campus, and interns can utilize a transit reimbursement program if they choose to use public transportation. Parking is not provided, but is available downtown in for-pay parking garages.

TRAINING TRACKS

The Consortium offers training tracks in the following areas: comprehensive/general, health psychology, neuropsychology, serious mental illness, trauma recovery, child outpatient, and school mental health. Interns who match to each track are provided with an organized training plan that includes year-long clinical training through rotation selection, minor rotations, research projects, and a didactic seminar series in their area. Please refer to Table 3: Consortium Track Requirements for an overview of track-specific training requirements.

VA-based Training Tracks

VA-based interns will have the opportunity to prioritize their preferences for rotation assignments at the beginning of the training year. A listing of typical rotation offerings is provided in Table 4: VA Rotations by Site. These rotations are offered on a regular basis and are generally available each training year. However, there may be times when staffing issues require cancellation of a rotation without advance notice. To ensure an optimal training experience, the number of interns that can be assigned to each rotation is limited; therefore it is not always possible for every intern to do all of their preferred rotations. The Training Director works with each intern upon their arrival to determine the best possible selection and scheduling of rotations.

Interns in the VA-based training tracks (Comprehensive/General, Neuropsychology, PTSD/Trauma Recovery, Health Psychology and Serious Mental Illness) complete three four-month major rotations during the year (two rotations based at Baltimore and one at either Perry Point or the Loch Raven Community Based Outpatient Clinic), which are based at VA facilities, with some opportunities for minor clinical rotations or research activities based at the School of Medicine. VA interns select rotation experiences based on their interest, availability, and institutional need.

Table 3: Consortium Track Requirements

Track	Number of Rotations Required Within Track	Minor Required Within Track	Research Required Within Track	Required Track Didactics
VA Comprehensive	Not Applicable	Not Applicable	Not Applicable	Not Applicable
VA Health	2	Not Required	Not Required	Yes
VA Neuropsychology	2	Yes	Available, Encouraged	Yes
VA Serious Mental Illness	2	Not Required	Available, Encouraged	Yes
UM Serious Mental Illness	Full Year	Not Required	Available, Encouraged	Yes
VA Trauma Recovery	2	Available, Not Required	Available, Not Required	Yes
UM Trauma Recovery	Full Year	Not Required	Not Required	Yes
UM Child Outpatient	Full Year	Not Applicable	Available, Encouraged	Yes
UM School Mental Health	Full Year	Not Applicable	Yes	Yes

Table 4: VA Rotations by Site

Site	Rotation	Page
Baltimore VA Medical Center	Addictions Treatment Program (ACT)	20
	Neurology	23
	Primary Care – Mental Health Integration	29
	Residential Rehabilitation Treatment Program (Trauma)	35
	Telemental Health	38
	Medical Psychology	21
Baltimore VA Annex	Neuropsychology	25
	Outpatient Trauma Recovery Program	32
	Psychosocial Recovery and Rehabilitation Center	31
Perry Point VA Medical Center	Geropsychology – Community Living Center	40
	Inpatient Treatment for Serious Mental Illness	44
	Mental Health Clinic	45
	Psychosocial Recovery and Rehabilitation Center	42
	Residential Treatment: Domiciliary, Addictions, and/or Psychosocial	49
	Primary Care – Mental Health Integration	47
Loch Raven Community Based Outpatient Clinic	Palliative Care	53

VA Comprehensive Track

Comprehensive Track interns complete three four-month rotations from any of the comprehensive list of available rotations (beginning on page 20). Examples of former Comprehensive interns' research projects have included:

- Assessing Self-as-context in the ACT IOP
- Racial Differences in Mental Health Recovery Orientation Among Veterans with Serious Mental Illness
- Smoking Norms Among Individuals with Serious Mental Illness

VA Health Psychology Track

Health Psychology interns complete two of the following four-month rotations and choose one additional rotation from the comprehensive list of available rotations (beginning on page 20).

- Neurology (Baltimore)
- Medical Psychology (Baltimore)
- Primary Care – Mental Health Integration (Baltimore)
- Primary Care – Mental Health Integration (Perry Point)Hospice/Palliative Care (Loch Raven)

In addition to the Consortium didactics seminar, Health Psychology interns participate in a monthly didactic seminar focused on advanced topics in Health Psychology assessment, intervention, and consultation. Topics are presented by the core Health Psychology staff, but the didactic is meant to stimulate thoughtful conversation about a variety of topics of interest to the interns.

Examples of former Health Psychology interns' research projects have included:

- The Effects of Health Behavior Motivation on Exercise and Autonomic, Cognitive, and affective Function Post Stroke
- Health Perceptions, Behaviors, and Coping in Veterans with Insulin Resistance or Type 2 Diabetes Completing an Exercise Intervention.

VA Neuropsychology Track

Consistent with Houston Guidelines, Neuropsychology Track interns spend a minimum of 50% of their training year involved in clinical, didactic, and research endeavors within neuropsychology. Interns in the Neuropsychology track are expected to complete two major rotations in Neuropsychology at the Baltimore VA Medical Center/Annex Building as well as a year-long minor rotation in Neuropsychology. Additionally, the intern may choose one major rotation of their choice. Training activities include outpatient and inpatient consultation as well as interdisciplinary assessment. Additionally, interns receive training in cognitive rehabilitation. Example training settings include Dementia Clinic, Cognitive Rehabilitation Clinic and general outpatient clinics.

In addition to patient specific supervision and the Consortium didactics seminar, neuropsychology interns participate in the following neuropsychology didactics and activities at various intervals:
Required

1) *Neuropsychology AM Report*
    a. Every Monday & Wednesday
    b. Time: 8:30 AM -9:00 AM
    c. Location: Neuropsychology conference room, 5th floor Annex
    d. Description:
        i. Interns present cases to be seen that day or in following days
        ii. Review approach to assessment and corresponding rationale
2) *Neuropsychology Case Conference*
    a. Every Tuesday
    b. Time: 2:30 PM-3:30 PM
    c. Location: Neuropsychology conference room, 5th floor Annex
    d. Description:
        i. All interns rotate presenting cases
        ii. Faculty occasionally present cases
        iii. Practice fact-findings are conducted
        iv. Report critiques are also periodically conducted
3) *Neurology Grand Rounds*
    a. Every Wednesday

b. Time: 9:00 AM-11:00 AM
c. Location: VA Auditorium (2nd Floor Main Hospital) *or* Neuropsychology conference room, 5th floor Annex
d. Description:
    i. Local and national experts present topics relevant to Neurology (10:00-11:00 AM)
    ii. Case presentation and discussion during 2nd hour

4) *Neuropsychology Fellowship Video Teleconference*
    a. Every Thursday
    b. Time: 1:00 PM-3:00 PM
    c. Location: Neuropsychology conference room, 5th floor Annex
    d. Description:
        i. Participating sites are Baltimore VAMC, Brooke Army Medical Center, National Rehabilitation Hospital, Tripler Army Medical Center, Walter Reed Army Medical Center, Washington DC VAMC
        ii. First hour – case conference, fellows rotate presenting cases
        iii. Second hour – presentation and discussion of assigned readings
        iv. Purpose is to prepare fellows for board certification in clinical neuropsychology
        v. Fellows actively participate, interns attend and complete assigned readings

5) Neuropsychology Treatment Group Supervision
    a. Every other Friday (alternates with Dementia Clinic Group Supervision)
    b. Time: 2:30 PM-3:30 PM
    c. Location: Neuropsychology conference room, 5th floor Annex
    d. Description:
        i. Ongoing cognitive rehabilitation and psychotherapy cases discussed
        ii. Didactic material presented by staff and fellows

6) Neuropsychology Dementia Clinic Group Supervision
    a. Every other Friday (alternates with Treatment Group Supervision)
    b. Time: 2:30 PM-3:30 PM
    c. Location: Neuropsychology conference room, 5th floor Annex
        i. Patients seen in Tuesday and Friday dementia clinics are discussed
        ii. Didactic material presented by staff and fellows

7) *Neuropsychology Journal Club*
    a. 1st Thursday of each month
    b. Time: 3:00-4:00 PM
    c. Location: Neuropsychology conference room, 5th floor Annex
    d. Description:
        i. Faculty/interns rotate selecting an article and leading the discussion
        ii. Review 1 empirical article relating to neuropsychology each meeting
        iii. Discuss methodological approach, results, and relevance to ongoing clinical work and research endeavors

Additional Training Opportunities

1) Neuroscience Seminar (VA/ University of Maryland)
    a. Weekly fall lecture series
    b. Time and location: vary each year

c. Sample topics: neuropsychological assessment; dementia; delirium; movement disorders; seizure disorders; neuroradiology)

2) *Brain Cutting (University of Maryland)*
   a. Weekly, Tuesdays
   b. Time: 8:30 AM
   c. Location: UM pathology lab (basement at UMMC)
3) *HIV/HCV Psychology Fellowship Training Seminar Series*
   a. Mondays from 12:00-1:00 PM
   b. https://vaww.portal.va.gov/sites/OMHS/HIV_HCV/default.aspx
4) *MIRECC Science Meetings*
   a. 2nd Tuesday of each month
   b. Time: 12:00 PM-1:00 PM
   c. Location: MIRECC conference room: 7th floor Annex
5) *Geriatrics Grand Rounds*
   a. 1st Friday of each month
   b. Time: 12:00 PM-1:00 PM
   c. Location: Baltimore VA Room 2B-136
6) *Psychopharmacology Case Conference*
   a. 1st Thursday of each month
   b. Time: 12:00 PM-1:00 PM
   c. Location: MSTF Auditorium (685 W. Baltimore St)
   d. Calendar posted here: http://medschool.umaryland.edu/psychiatry/default.asp
7) *UM Department of Psychiatry Grand Rounds*
   a. 3rd Wednesday of each month
   b. Time: 2:30 PM- 3:45 PM
   c. Location: either 737 West Lombard St. 4th floor
   d. Contact Dr. Nancy Lever (410-706-4974) or Dr. Laurel Kiser (410-706-2490) for more information.
8) *Neurology Town and Gown (University of Maryland Medical Center)*
   a. Day-long seminar series on current topics in neurology; current UM faculty present along with neurologists practicing in the community
   b. Mix of clinically-oriented and research-oriented presentations
   c. Typically occurs in June
   d. All neuropsychology trainee strongly encouraged to attend

Neuropsychology Track Interns are encouraged to conduct their research project in an area related to Neuropsychology. Example research projects include:

- Relationship between Cognitive Scores, Psychotic Symptoms, and Performance Validity in two Samples of Veterans with Serious Mental Illness
- Cognitive Rehabilitation in Multiple Sclerosis
- Cognitive Telerehabilitation in Patients with MS: Preliminary Findings
- Effects of Exercise and Cognitive Rehabilitation on Executive Functioning in Parkinson's Disease

<u>VA Serious Mental Illness Track (SMI)</u>

VA-based SMI interns complete two of the following four-month rotations and choose one additional rotation from the comprehensive list of available rotations (beginning on page 20).

Inpatient Psychology (Perry Point)

- Psychosocial Rehabilitation and Recovery Center (Baltimore)
- Psychosocial Rehabilitation and Recovery Center (Perry Point)

In addition to the Consortium didactic seminar, SMI interns participate in a monthly didactic seminar focused on psychosocial treatments and recovery. The didactic series is held in collaboration with the VA's Interprofessional Fellowship in Psychosocial Rehabilitation and Recovery Oriented Services (PSR Fellowship). The 2014-2015 schedule is provided as an illustrative example of what an intern might expect to participate in during their training year:

Topic	Presenter	Month
Psychosocial and Family-Based Interventions for Bipolar Disorder	Anjana Muralidharan, PhD MIRECC Postdoctoral Fellow	September
Social Cognition and SMI	Clare Gibson, PhD VAMHCS	October
The Recovery Model	Jason Peer, PhD VAMHCS	November
CBT for Psychosis	Dimitri Perivoliotis, PhD San Diego VA	January
Trauma informed care with People in Recovery from SMI	Stephanie Sachs, PhD DC VA	February
Problem Solving Therapy	Bruce Levine, PhD MIRECC VISN 3	March
Motivational Interviewing	Noosha Niv, PhD MIRECC VISN 22	April
Community Integration Strategies	Alison Taylor, OTR/L Durham VA	May
Acceptance and Commitment Therapy	Rebecca Pasillas, PhD El Paso VA	June

**Note* seminars from January-June are sponsored by the PSR fellowship cross-site seminar series.

Additional training activities include the opportunity to participate in the MIRECC pharmacology case conference monthly call, MIRECC monthly journal club, and the Recovery Center Steering committee.

Former interns have completed research projects with researchers from the Mental Illness Research, Education, Clinical Center (VISN 5 MIRECC is focused on SMI and recovery) and Maryland Psychiatric Research Center (MPRC). Some examples of former interns' research projects include topics related to perceived social stigma and self-stigma, models of shared decisions making among consumers diagnosed with SMI, cognitive functioning in individuals with Schizophrenia, and qualitative outcomes of social skills interventions.

VA Trauma Recovery Track

Trauma Recovery Track interns complete two of the following four-month rotations and choose one additional rotation from the comprehensive list of available rotations (beginning on page 20).

- PTSD Clinical Team (PCT) Outpatient Program (Baltimore)
- Residential Rehabilitation Treatment Program (RRTP) (Baltimore)
- Telemental Health Delivery of Evidence-Based Practices for PTSD (Perry Point)

In addition to the Consortium didactic seminar, Trauma Recovery Track interns will participate in a monthly didactic seminar focused on advanced topics in PTSD assessment, intervention, and consultation. The 2014-2015 schedule is provided as an illustrative example of what an intern might expect to participate in during their training year:

Topic	Presenter	Month
CAPS-5 Administration	Melissa Barone, PsyD	July
Prolonged Exposure	Melissa Barone, PsyD	August
Cognitive Processing Therapy	Stephanie Sacks, PhD	September
Symptom Validity in PTSD Assessment	Dave O'Connor, PhD	October
Mindfulness Based Interventions	Andy Santanello, PsyD	November
Cognitive Behavioral Treatment for Insomnia	Ann Aspnes, PhD	December
ACT for PTSD	Josh Semiatin, PhD	January
Treatment with Perpetrators of Violence	Rachel Thompson, PhD	February
STAIR	Erin Burns, PhD	March
PE in Primary Care Settings	Ann Apnes, PhD	April
Virtual Reality Treatment for PTSD	Erin Romero, PhD	May
Conjoint Therapy for PTSD	Josh Semiatin, PhD	June

Additional training activities include group supervision, CPT Consultation Group, PE Consultation Group, journal club, and Trauma Consultation Group (peer-led group for faculty and interns focused on self-care, professional development, and processing therapists' reactions related to trauma work).

Examples of former interns' research projects include topics related to PTSD self-stigma, program evaluation in outpatient clinics, evaluation of religious coping for PTSD, and integration of wellness strategies into MST programming.

UMB-based Training Tracks

Tracks associated with the University of Maryland Baltimore are located within the School of Medicine and the Department of Psychiatry at the University of Maryland Medical System (UMMS). Interns who match with UM SOM tracks are assigned to year-long placements within community psychiatry clinics and/or school settings. There are also opportunities for clinical minors or research activities based at the VA medical center, though these offerings vary depending on UM SOM training track requirements. Tracks include Serious Mental Illness, Trauma Recovery, Child Outpatient, and School Mental Health.

The combination of a broad range of treatment programs, client needs, and psychology personnel involved with the UM SOM tracks ensure opportunities for intensive and extensive experiences that can meet most professional training needs. These experiences include providing comprehensive and multidisciplinary intervention and assessment services to clients, participation interdisciplinary staff conferences, and didactic training. Interactions with the clinic team members enable interns to improve efficacy in working on multidisciplinary teams and to share and/or demonstrate their unique abilities and skills. At the start of internship, one week is devoted to orientating interns to their track, clinical training sites, supervisors, program instructors, and available seminars and minors. Interns and their supervisors develop an individualized training program which may be reviewed for modification throughout the training year, if necessary.

UM SOM Adult-Focused Tracks

The Department of Psychiatry at the University of Maryland School of Medicine has a long history of serving patients in the public sector in the Baltimore metropolitan area and hosts the UM SOM SMI and Trauma Recovery track interns. These interns participate in a year-long placement at one of two University of Maryland Medical System mental health clinics: (1) the Adult Outpatient Psychiatry Clinic (Trauma Recovery Track) or (2) the Community Fayette Adult Clinic (SMI Track). Both are located at the Walter P. Carter Center building at 701 West Pratt Street, Baltimore. The focus of both placements is adult psychology and community psychiatry. Both sites assist individuals 18 and older with a wide range of mental health problems, many of whom also experience co-occurring substance use and medical illness problems. Both have created service environments which emphasize the Recovery Model, in which client strengths are highlighted and clients are empowered to be the primary decision makers in their own care. Over the past several years, both clinics increased attention to the impact of trauma on daily functioning and symptom presentation. This has led to the implementation of a trauma-informed approach to care.

Serious Mental Illness (SMI) - Community Fayette Clinic

At the Fayette Clinic, approximately 65-75 percent of the individuals served are seriously and persistently mentally ill. Individual, group (e.g., Social Skills Training) and family therapies are available, as well as medication management, case management, and substance abuse services. The track is structured to include involvement in clinical research projects conducted by DSR, CBTS and/or MIRECC faculty. These interns may have the opportunity to implement manualized research treatments in addition to their regular clinical placement.

Trauma Recovery - Outpatient Psychiatry Clinic

At the Adult Outpatient Psychiatry Clinic, service recipients are between 18 and 65 years of age, the majority being diagnosed with affective and anxiety disorders. The clinic has developed a trauma informed approach to care given that the majority of our clients have been subjected to childhood and/or adult trauma that influences

their symptoms and response to treatment. Treatment modalities in the clinic include individual psychotherapies (e.g., psychodynamic, interpersonal, supportive, brief, CBT), group therapy, and medication management. Additional training opportunities exist for learning DBT, motivational interviewing, and other empirically supported interventions.

UM SOM Child-Focused Tracks

The UM SOM child track interns participate in two concurrent year-long rotations. Three interns will complete the school mental health rotation within the University of Maryland Center for School Mental Health and one intern will complete outpatient rotations within the Taghi Modarressi Center for Infant Study and the Child and Adolescent Outpatient Service. These training experiences are described in greater detail beginning on page 54.

CLINICAL ROTATIONS AND TRAINING STRUCTURE

Clinical Rotations – Baltimore VA Medical Center and Annex

Addictions Treatment Program

Patient Population

The primary setting for this rotation is the intensive outpatient (IOP) component of the Acceptance and Commitment Program (ACT) at Baltimore. The ACT Program is a 12-week dual diagnosis program (substance abuse and PTSD) beginning with the four- to five-week IOP for Veterans with substance use disorders. Over 90% of ACT patients are male, 75% are members of a racial or ethnic minority group, and the median age is 45 years old. The most commonly encountered substances of abuse include alcohol, heroin (opiates), and cocaine. Other presenting addictions include to benzodiazepines, marijuana, and prescription narcotics. The majority of this population is medicated for co-occurring psychiatric illness, including PTSD, depression, bipolar illness, and severe mental illness.

Assessments, Treatments, & Supervision

During this rotation, interns will be provided with training in individual and group psychotherapy for the treatment of substance use disorders as well as co-occurring disorders, including PTSD, mood disorders, and other mental illnesses. Training and supervision will include systematic didactic and psychotherapeutic exposure to the following empirically validated psychotherapeutic approaches to treatment:

a. The fundamentals and core change components of group psychotherapy, as researched by Yalom (1995) and fundamentals of interpersonal process therapy (IPT) in individual and group settings (Klerman et al., 2004).
b. Extensive exposure to mindfulness-based interventions for addictions and other disorders, including Mindfulness-Based Relapse Prevention (Bowen, 2011).
c. Methods of working with resistance and clarification of goals and values, through empirically demonstrated mindfulness strategies (Breslin, Zack, & McCain, 2002; Brown & Ryan, 2003; Hayes, 2003; Wilson, Hayes, & Byrd, 2000) within the framework of Acceptance and Commitment Therapy (ACT), Functional Analytic Psychotherapy (FAP; Kohlenberg, Hayes, & Tsai, 1993), as well as Dialectical Behavior Therapy (DBT; Linehan, 1993).
d. Cognitive-behavioral interventions for the prevention of relapse (Brownell, Marlatt, Lichtenstein, & Wilson, 1986) focusing on the primacy of negative affect in relapse.
e. Interns will also be trained in the fundamentals and application of Motivational Enhancement Therapy (MET; Miller & Rollnick, 1991), particularly the technique of motivational interviewing as it applies to the phases of change model of motivation (Prochaska, DiClemente, & Norcross, 1992).

Interns will participate on an interdisciplinary treatment team and will co-facilitate group therapy three times weekly, co-facilitate at least two psychoeducation groups monthly, and carry individual patient caseloads.

Interns will conduct full psychosocial assessments to include the diagnosis of, and differentiation of mild, moderate, and severe substance use disorders, learn the pharmacological correlates of behavior for major classes of substance use disorders, and differentiate and understand the phenomenological comorbidity of substance use disorders, PTSD, mood disorders, and other psychiatric disorders. Interns will employ the use of such standard instruments as the Beck Depression Inventory (Beck *et al*., 1961), Beck Anxiety Inventory (Beck & Steer, 1990), Minnesota Multiphasic Personality Inventory-2 (Butcher *et al*., 1989), Personality Assessment Inventory (PAI, Morey, 1991), etc., and learn how to assess for PTSD using the Clinician-Administered PTSD Scale (CAPS; Blake *et al*., 1995) and various other trauma measures.

Each intern will case manage six to eight individual patients through the four to five week intensive outpatient program, and will follow two to three individual patients following this rehabilitation through the stages of early recovery as part of their aftercare. They will also receive two hours of face-to-face individual supervision per week in addition to two hours of group supervision per week.

Supporting Literature

Project MATCH represents one of the largest and most comprehensive substance abuse treatment outcome studies to date (Project MATCH Research Group, 1997). Investigators followed over 1,700 alcohol-dependent clients for up to 3 years after they received treatment in one of three conditions: 12-Step Facilitation (TSF), Cognitive Behavioral Coping Skills Therapy (CBT), or Motivational Enhancement Therapy (MET). It was hypothesized that when clients are matched with the appropriate treatment approach, that outcomes would improve. On the contrary, clients in all of the treatment conditions improved, regardless of matching, and there was little difference in outcome among the three approaches.

The addiction intensive outpatient program at Baltimore has sought to improve patient outcomes by utilizing elements of TSF, CBT, and MET in its treatment programming. In 2004, when tasked with integrating aspects of its programming with that of the PTSD/Substance Abuse Residential Rehabilitation Treatment Program (PRRTP), it was decided that a more unified treatment model was needed that: 1) would be relevant in the conceptualization and treatment of both PTSD and substance abuse, as well as other emotional/behavioral disorders; and 2) would provide a less fragmented, more coherent treatment experience. In collaboration with the Trauma Recovery team, the principles and strategies of Acceptance and Commitment Therapy (2008) were adopted.

Supervisors' Training & Experience

James Finkelstein, Psy.D. is the primary supervisor for this rotation. Dr. Finkelstein earned his Psy.D. in 2003 from Loyola College in Maryland and completed his internship here at the Baltimore VA. He has continued to work as the lead psychologist in the ACT Program, supervising interns and externs in group and individual therapy, as well as facilitating an ongoing ACT consultation and training group. He has published research in the area of etiology of PTSD, psychopharmacology in psychological practice, and ethics in clinical practice. He continues to teach and lecture in the community on ACT, Mindfulness, Group Therapy, and Addictions.

Medical Psychology Rotation

Patient Population

Interns will have the opportunity to work with three medical populations during this rotation: individuals with chronic Hepatitis C, individuals with HIV infection, and individuals with end-stage organ diseases or life-threatening blood diseases who are being considered for solid organ or bone marrow

transplantation. Additionally, there may be some exposure to mental health evaluations for individuals who are being considered for bariatric surgery.

Patients with Hepatitis C: These patients are referred to this specialty medical clinic when diagnosed with Hep C. The average age range is 50s to 70s. The majority of the patients are male (90%) and about 75% of the patients are African-American. The most common psychiatric comorbidities are Substance Use Disorders and Major Depressive Disorder.

Patients with HIV: These patients are seen in the Infectious Disease (ID) clinic, which functions as a primary care clinic. The age range is 20s to 70s, 95% of the patients are male, approximately 90% are African-American, and the majority are of lower socioeconomic status. Approximately 10-15% of the patients carry a diagnosis of AIDS. Overall, these patients tend to have multiple co-morbid medical conditions (such as diabetes, hypertension, chronic pain). The most common psychiatric comorbidities are Substance Use Disorders and Major Depressive Disorder.

Patients who are being considered for transplantation: These patients are referred for psychological assessment as part of a comprehensive medical evaluation to determine their suitability for solid organ or bone marrow transplantation. Most of the patients are male and range in age from late 40s to mid 60s; approximately 40%-50% are African-American. The most common psychiatric comorbidities are Adjustment Disorder and Major Depressive Disorder.

Assessments, Treatments, & Supervision

Hepatitis C Clinic: In this clinic, interns will learn about the ever changing Hepatitis C medications and become a member of the interdisciplinary team. The intern will learn to complete evaluations for Hep C treatment that assess current mental health stability and readiness for treatment. The evaluation is comprised of a psychosocial interview and brief self-report instruments (e.g., BDI, BAI, mental health locus of control) and the Montreal Cognitive Assessment. Interns will provide recommendations to the patients and their Hep C providers. Interns can expect to complete about 15 Hep C pre-treatment evaluations. The intern will also provide brief therapy to Veterans undergoing treatment who experience difficulty complying with the medication regimen and/or difficulty maintaining healthy lifestyle changes. The expected case load is 3 patients. Motivational interviewing is the most commonly used therapeutic intervention. Additionally, the intern has the opportunity to participate in the weekly Hep C education group and monthly support group.

Infectious Disease Clinic: In this setting, interns will learn to complete brief, focused psychological assessments of patients with HIV/AIDS by conducting clinical interviews supplemented by instruments that can be administered and interpreted quickly (e.g., the BDI, BAI, and the Montreal Cognitive Assessment). Interns will provide verbal feedback and recommendations to the patients' physicians based on the results of their assessments. Interns can expect to complete 4-5 assessments of HIV+ patients. Interns will also have the opportunity to conduct individual psychotherapy, which is typically short-term and problem-focused. Expected caseload is 3 patients. Appropriate strategies include: cognitive-behavioral skills training (including relaxation and stress management), motivation enhancement, and supportive therapy.

Transplant Consults: Interns will utilize a semi-structured interview designated for VA-wide use as part of their psychological assessment of candidates for transplantation. This interview will be supplemented by review of the patient's electronic medical chart, administration of the BDI and BAI (to assess symptoms of affective distress), administration of the Montreal Cognitive Assessment), and administration of the PAI or MBMD (to determine if the patient is engaging in impression management and to assess personality functioning). Based on an integration of these sources of data, the intern will make a judgment about the patient's current psychosocial readiness for transplantation and, if appropriate, make recommendations for increasing the patient's transplant readiness. Interns can expect to complete 3-4 transplant evaluations.

Supporting Literature

Hepatitis C Clinic: Depression, irritability, and anxiety are often comorbid conditions within individuals who have HCV. This can lead to problems with treatment compliance, difficulty coping with the chronic illness, and impairments in personal life (Angelino & Treisman, 2005). Cognitive-behavioral therapy (addressing depression and stress management) and problem solving therapy have been shown effective in symptom management and increasing medication/treatment compliance (Evon et al., 2012).

Infectious Disease Clinic: Stress management group interventions that incorporate relaxation training and behavioral coping skills training have been found to improve psychosocial and immunological outcomes in HIV+ individuals (Antoni, 2003), although on this rotation, skills training is done in an individual therapy format. Results of a randomized clinical trial showed that interpersonal psychotherapy and supportive psychotherapy supplemented by antidepressant medication were more effective than CBT or supportive therapy without antidepressant medication for treating depressive symptoms in individuals with HIV infection, although all treatments significantly reduced depression in this population (Markowitz, et al., 1998).

Transplant Consults: A number of psychosocial variables have been found to be predictive of post-transplant outcomes. For example, having a psychiatric disorder is associated with poor health status after transplant (Chacko, Harper, et al., 1996), having a personality disorder diagnosis predicts problems with post-transplant medical compliance (Chacko, Harper, et al., 1996), poor social support is associated with decreased survival after transplant (Chacko, Grotto, et al., 1996), and substance abuse predicts poor post-transplant medical compliance (Shapiro et al., 1995). The pre-transplant psychological evaluations completed by interns on this rotation include assessment of all the psychosocial variables that have been identified in the literature as important for determining how well patients fare after transplant.

Supervisor's Training & Experience

Interns on this rotation will receive 2 hours of scheduled, face-to-face supervision each week from Dr. Schneider. Dr. Schneider is also available for additional supervision or consultation as needed, by phone or in person. Dr. Schneider earned her doctorate in clinical psychology from La Salle University with a health psychology concentration. She focused on chronic pain, coping, and acceptance of pain during her graduate training. She completed her internship at the Miami VA Medical Center, with training in the psychological assessment and treatment of various geriatric and medical patient populations, including cancer, medical inpatient consultation and liaison, hospice/palliative care, chronic pain, and transplant. She then completed a one-year postdoctoral fellowship at Salem VA Medical Center, with a focus on primary care-mental health integration and behavioral medicine (chronic pain, diabetes, transplant, and bariatric surgery candidates). Dr. Schneider's career experiences have focused on chronic disease management, coping with chronic illness, health behavior changes, and chronic pain management.

Health Psychology - Neurology

Patient Population

Interns will have the opportunity to work with two medical populations during this rotation: individuals with chronic non-cancer pain, including headaches, and individuals with sleep disorders. The setting is within the Department of Neurology, under the Chronic Pain Management and Sleep Medicine Services.

Patients with chronic pain: The Chronic Pain Management service operates as a consultative service for patients with chronic pain. These patients have been referred by their primary care providers, orthopedic providers, or similar, to the VAMHCS chronic pain specialty clinic for re-evaluation of their pain management plan. The duration of time spent with the specialty clinic ranges from one visit to long-term (e.g. 1 year) depending on the individual's assessment and plan. The age range is 20s to 80s, 20 to 25%

of the patients are female, and approximately 50% are African-American. The most common presenting medical complaint is spinal pain. The most common co-occurring psychiatric disorders are Major Depressive Disorder and PTSD.

Patients with sleep disorders: These patients are seen in the Neurology Sleep Medicine clinic. Veterans are referred for evaluation of sleep-related disorders including apneas, restless leg syndrome, circadian rhythm disorders, and insomnia. The age range is 20s to 80s, 25% of the patients are female, and approximately 50% are African-American. Patients are evaluated first by the sleep medicine team and then referred to the health psychologist for CBT-I or other behavioral treatments. The most common co-occurring psychiatric disorders are Major Depressive Disorder and Anxiety Disorders/PTSD.

Assessments, Treatments, & Supervision

Chronic Pain Clinic: Interns will perform a comprehensive psychological evaluation of patients who are presenting to the Pain Clinic for their initial visit. This evaluation consists of: a semi-structured interview, a review of the patient's electronic medical chart, the Patient Health Questionnaire (PHQ-9), the Beck Anxiety Inventory (BAI), the Primary Care PTSD Screen (PC-PTSD), and the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R). In addition, all patients are asked to complete the numerical pain scale and interference items from the Brief Pain Inventory to assess pain severity and impact on function. Based on their interests, interns have the opportunity to use other pain-specific assessment instruments, such as the Multidimensional Pain Inventory (MPI), the Pain Catastrophizing Scale (PCS), and the Short Form McGill Pain Questionnaire (SF-MPQ) as well as health psychology-specific instruments such as the Millon Behavioral Medicine Diagnostic (MBMD). Interns can expect to complete at least five comprehensive evaluations of pain patients, and can expect to communicate findings to and collaborate on treatment plans with medical providers, both orally in clinic and verbally through written reports.

Interns will receive training in a variety of empirically-supported behavioral interventions for the treatment of chronic pain patients. Individual treatments offered to pain patients include biofeedback and cognitive-behavioral therapy for chronic pain. Expected caseload is three to five patients. Interns are expected to co-lead a CBT-CP group. Interns will be expected to participate in the monthly Interdisciplinary Pain Team meeting (IDT), during which the most complex pain patients are discussed for coordination of care among pain specialty providers, mental health, and primary care. In addition, interested interns may receive training in assessment and treatment of chronic patients with co-occurring substance use problems, conduct ACT for Chronic Pain (ACT-CP), or other interventions (e.g. Mindfulness Based Stress Reduction for chronic pain).

Sleep Clinic: In this setting, interns will learn to complete focused psychological assessments of patients with sleep disorders by conducting clinical interviews supplemented by sleep and fatigue instruments such as the Insomnia Severity Index (ISI), The Pittsburgh Sleep Quality Index (PSQI), and the Epworth Sleepiness Scale (ESS), as well as psychiatric instruments such as those listed above for pain clinic. Interns will provide verbal and written feedback and recommendations to the patients' sleep and primary care physicians based on the results of their assessments. Interns will be to conduct Cognitive Behavioral Therapy for Insomnia (CBT-I) in individual and group formats. Expected caseload is three to five patients. Interns will be expected to attend monthly administrative interdisciplinary sleep meetings with representation from sleep medicine and home oxygen. Finally, interns may have the opportunity to attend "Sleep Boot Camp" which is a 2-3 day education program for incoming sleep medicine fellows at the University of Maryland.

Centers of Excellence – MS and Epilepsy: Housed within the department of Neurology, Baltimore is the coordinating center for all MS Centers of Excellence in the region and for a number of studies related to the diagnosis, monitoring, and treatment of Multiple Sclerosis and Epilepsy. While not oficially part of

the rotation, interested interns may find opportunities for assessment and intervention within this service, for example, CBT for nonepileptic seizures. Other interns have taken "general neurology" health psychology cases, including tic disorders and polymyositis.

Supporting Literature

Chronic Pain Clinic: There is ample empirical support for the use of cognitive-behavioral therapy in patients with chronic pain, whether in individual sessions or in a group format (*e.g.*, Basler, Jaekle, & Kroener-Herwig, 1997; Keefe *et al.*, 1990; Turk, 2003). Also, a CBT intervention specifically targeted to treat insomnia has been found efficacious for sleep disturbances secondary to pain (Currie *et a*l., 2000). Relaxation training is widely recognized as useful for treating chronic pain and a recent Cochrane evidence-based medicine review supported its use (Ostelo *et al*., 2005). Biofeedback training (which incorporates relaxation) has been found to be clinically useful for the treatment of headaches (as reviewed in Arena & Blanchard, 2002) as well as for chronic musculoskeletal pain (Flor & Birbaumer, 1993). Finally, emerging evidence suggests that Acceptance and Commitment Therapy-based interventions also are promising for treating a chronic pain population (Dahl, Wilson, & Nilsson, 2004).

Sleep Clinic: The Behavioral Model of Insomnia (Spielman, *et al.*, 1987) is the most widely cited theory regarding the etiology of chronic insomnia. Cognitive Behavioral Treatment of Insomnia (CBT-I; see Morin *et al.*, 2008), an empirically-supported behavioral treatment for insomnia, utilizes components such as Stimulus Control Therapy (SCT), Sleep Restriction Therapy (SRT), Sleep Hygiene Education, Relaxation Training, and Cognitive Therapy.

Supervisor's Training & Experience

Interns on this rotation will receive two hours of scheduled, individual face-to-face supervision each week from Sara Clayton, Ph.D. Dr. Clayton is also available for additional supervision or consultation as needed, by phone or in person.

Dr. Clayton earned her doctorate in clinical psychology from the University of Wyoming, focusing on behavioral and psychological factors related to HIV during her graduate training. She completed her internship at the Baltimore VA Medical Center - Health Psychology track, with training in the psychological assessment and treatment of various patient populations, including primary care, infectious diseases, chronic pain, transplant candidates, PTSD, and substance abuse. She went on to complete a postdoctoral fellowship at the University of Maryland School of Medicine, where her research and clinical duties involved patients with HIV, depression, and substance abuse. Dr. Clayton also has experience working with adolescent medical patients. Dr. Clayton has presented her research at meetings of the Society of Behavioral Medicine and the Association for Behavioral and Cognitive Therapies. She is currently a consultant for the VA evidence-based training program in insomnia.

Dr. Perra earned her doctorate in clinical psychology from Loyola University Maryland, where she worked in academic medical centers and community health centers with patients dealing with a range of chronic illnesses, including HIV, stroke, spinal cord injury, and chronic pain. She completed her internship at the Medical College of Georgia/Charlie Norwood VA Medical Center consortium in the Medical Psychology track, where she had the opportunity to work in a variety of areas in general and medical psychology. She joined the VA Maryland Health Care System for a postdoctoral fellowship in health psychology, specializing in assessment and treatment of patients with HIV and hepatitis C. Her current clinical and research interests include developing and growing interdisciplinary treatment teams, cognition and chronic illness, and clinical supervision.

Neuropsychology

General

The Neuropsychology Specialty Track within the VAMHCS/UMMS Consortium adheres to criteria and guidelines developed by Division 40 of the American Psychological Association, the Association of Internship Training in Clinical Neuropsychology, and the Houston Conference on Specialty Education and Training in Clinical Neuropsychology. Accordingly, interns will spend a minimum of 50% of their training year involved in clinical, didactic, and empirical endeavors in neuropsychology. The program is designed to prepare students for post-doctoral fellowships in neuropsychology. To achieve this objective, interns in this program will do two full rotations in neuropsychology at the Baltimore Medical Center/Annex and their research experience will be focused in areas pertinent to neuropsychology. During the third rotation, the intern maintains a minor rotation in our service. Interns are encouraged to attend regional and national conferences. Our previous interns have been successful in obtaining post-doctoral fellowships both locally and nationally and opportunities may exist for interns to develop their own research funding to support post-doctoral training endeavors.

Patient Population

Veterans with medical, neurological, and psychiatric disorders are referred from various clinics and units throughout the medical center for neuropsychological assessment. Diagnoses include neurodegenerative, neuropsychiatric, endocrine, infectious, seizure, and vascular disorders as well as tumor and head trauma. We also see patients referred for war-related injuries and complaints. Patients come from different ethnic backgrounds and from all adult age ranges. In view of the Veteran population served, a substantial number of patients are 50 years of age and older, although changes in this population have led to increasing referrals of returning Veterans, who have been as young as 22 years old.

Assessments, Treatments, & Supervision

Neuropsychology is primarily a consultative and assessment service. Test batteries vary depending on the level of impairment of the patient and the nature of the referral question. Interns learn test administration via direct observation and mentoring. Once interns can function autonomously, they interview patients with the supervisor and then proceed with the assessment. Patient histories and examination findings are reviewed with the intern. Interns generate reports that are reviewed in detail by their supervisor(s). During the major neuropsychology rotations, interns assess 1-2 outpatients and 1-2 dementia clinic patients per week.

Treatment is also an integral component to the internship program. Interns will have a minimum of 1-2 outpatient treatment experiences (e.g., cognitive rehabilitation, psychotherapy, dementia follow-up, other groups) throughout the training year. Experiences providing treatment may be available during Neuropsychology minor rotations.

We utilize a tiered supervision model. Therefore, at times interns will be supervised, in part, by postdoctoral fellows and in turn, they may have the opportunity to provide supervision to externs.

In addition to weekly individual and group supervision within the Neuropsychology section, interns may attend the following activities at various intervals:

1. Neuropsychology Fellowship Video-Teleconference with VA/DoD Sites
2. Neuropsychology case conference
3. Neuropsychology morning report
4. Geriatric assessment clinic supervision
5. Neuropsychology treatment supervision
6. Neurology grand rounds
7. Neuropathology rounds
8. Neuropsychology journal group

9. Geriatric psychiatry rounds
10. Psychiatry Neuroscience Course
11. Select meetings of the MS Center of Excellence
12. Select meetings of the Epilepsy Center of Excellence

Research

Interns are required to complete a research project during the internship year. The general expectation is for interns to formulate a novel research question at the beginning of the year, gather/analyze data throughout the year, and present results at the end of the year. Please see the attached sheet for a description of ongoing research studies.

Clinical Training Program

The VAMHCS Neuropsychology section takes pride in the breadth and depth of our training programs. In addition to internship training, VAMHCS Neuropsychology staff actively participate in training 2-4 doctoral candidates per year in formal externships. VAMHCS Neuropsychology also has an established two-year, APA-accredited general Clinical Neuropsychology postdoctoral fellowship. Two additional postdoctoral fellowship programs were recently established, with fellows initially enrolling in these programs in September 2014. These new programs include a one-year joint fellowship in Health Psychology and Neuropsychology with an emphasis in HIV/Hepatitis C and a two-year Clinical Neuropsychology fellowship in the assessment and treatment of neurologic disorders.

Our training model is based on information and recommendations from The American Board of Professional Psychology, Division 40 of the American Psychological Association, the Association of Internship Training in Clinical Neuropsychology, and the Houston Conference on Specialty Education and Training in Clinical Neuropsychology.

VAMHCS Neuropsychology Staff: Training & Experience

Moira Dux, Ph.D. is the Co-Training Director for the VA Postdoctoral Fellowship in HIV/HCV. She earned a doctorate in clinical psychology from Rosalind Franklin University of Medicine and Science, in the program's neuropsychology track. She completed her pre-doctoral training (neuropsychology track) at the VA Maryland Health Care System/ University of Maryland Medical Center. She then completed a research neuropsychology fellowship at the Baltimore VA. Dr. Dux was the recipient of a VA Career Development Award examining the effects of high-intensity aerobic exercise on autonomic, cognitive, and affective function post-stroke. Primary research interests include evaluation of exercise and cognitive rehabilitation therapies to improve cognitive, psychological, and physical function in neurologic and chronic disease populations (e.g., HIV/HCV, stroke, MS).

Anjeli Inscore, Psy.D., ABPP-CN is the Director of Training for the Postdoctoral Fellowship in Clinical Neuropsychology. She earned a doctoral degree from Loyola University. She completed a one-year research postdoctoral fellowship in rehabilitation psychology and neuropsychology at the Johns Hopkins Department of Physical Medicine and Rehabilitation. She then completed a two-year clinical postdoctoral fellowship in neuropsychology at the Johns Hopkins Department of Psychiatry and Behavioral Sciences. Dr. Inscore holds an appointment as a Research Associate at the University of Maryland, School of Medicine. Her research is in conjunction with the University of Maryland and the VA Geriatric Research Education and Clinical Center (GRECC) with a primary interest in the neurocognitive, psychological, and health benefits of exercise in overweight and obese individuals. She received a Nutrition Obesity Research Center (NIDDK-funded) Pilot and Feasibility grant to study yoga as an intervention to treat obesity in postmenopausal women. She also has a research interest in geriatrics/dementia and is in the process of creating archival and prospective databases that will include

medical, functional, and cognitive data on patients evaluated in the Geriatric Assessment and Dementia Evaluation, Management, and Outreach (DEMO) clinics.

Terry Lee-Wilk, Ph.D. is the Director of Neuropsychology and Co-Director of the Postdoctoral Fellowship in Clinical Neuropsychology with an Emphasis in Neurologic Disorders. Dr. Lee-Wilk earned a doctorate in clinical/community psychology from the University of Maryland College Park. She completed internship at the University of Maryland Baltimore in Child Psychiatry and one year of postdoctoral training at Children's National Medical Center. She subsequently completed a two-year postdoctoral fellowship in Neuropsychology at the VAMHCS/University of Maryland School of Medicine. She is the lead neuropsychologist at the Multiple Sclerosis Centers of Excellence and is also very involved with the Infectious Disease clinics. She serves as a volunteer clinical instructor at the University of Maryland, Department of Pediatrics. Currently, her research is related to cognitive tele-rehabilitation for patients with multiple sclerosis.

Kristen Mordecai, Ph.D. is the Co-Director of the Postdoctoral Fellowship in Clinical Neuropsychology with an Emphasis in Neurologic Disorders. She earned a Ph.D. in clinical psychology from Rosalind Franklin University of Medicine and Science, in the program's neuropsychology track. She completed her pre-doctoral training in clinical psychology focused in general and geriatric neuropsychology within the Boston Consortium in Clinical Psychology at the Veterans Affairs Boston Health Care System. Her two-year postdoctoral fellowship in neuropsychology was completed at the Veterans Affairs Maryland Health Care System within the Integrated Fellowship in Traumatic Brain Injury and Trauma Recovery in Returning Veterans program. She is the Neuropsychology liaison at the Baltimore VA Epilepsy Center of Excellence. Her research interests include the cognitive effects of neurologic conditions such as Parkinson's disease, dementia, and MS as well as the development of cognitive rehabilitation and telemental health programs to address cognitive symptoms.

Patricia Ryan, Ph.D. earned a Ph.D. in counseling psychology from Fordham University, after obtaining a master's degree in developmental psychology from Teachers College, Columbia University. She completed her internship and additional postdoctoral training at the Rusk Institute of Rehabilitation Medicine, New York University Medical Center. Dr. Ryan also completed a two-year postdoctoral fellowship in rehabilitation psychology and neuropsychology at the Johns Hopkins Department of Physical Medicine and Rehabilitation. She is a member of the interdisciplinary Polytrauma Support Clinic Team, working with Veterans with traumatic brain injury. Within that clinic and the general consultation clinic, she provides assessment, cognitive rehabilitation and psychotherapy for Veterans with traumatic and acquired brain injury. Her research interests include the efficacy of various cognitive remediation modalities, as well as depression after TBI and stroke. She is currently a research team member on a multi-site randomized control trial of multifamily group treatment in returning Veterans with a history of mild TBI.

John Sawyer, Ph.D. earned his MS in Marriage and Family Therapy from the University of Southern Mississippi and his Ph.D. in Counseling Psychology from The University of Memphis. He completed his pre-doctoral training (neuropsychology track) at the Memphis VA Medical Center. He then completed his neuropsychology post-doctoral fellowship at the Baltimore VA Medical Center in 2014. Dr. Sawyer is presently a staff neuropsychologist and affiliate faculty at Loyola University Maryland. Research interests include studying performance validity tests, performance validity test development, and the impact of effort on neuropsychological assessment. Clinical interests include geriatrics, stroke, TBI, and learning disabilities. He's also interested in program development and cognitive rehabilitation/psychotherapy.

Megan M. Smith, Ph.D. obtained her doctorate in clinical psychology from The Pennsylvania State University. She completed her predoctoral clinical internship and postdoctoral training in clinical

neuropsychology at Brown University. From 2009-2014, she was an assistant professor in the Department of Psychiatry at the Carver College of Medicine at the University of Iowa. Her major areas of research interest are cognition in neurodegenerative disorders and the neuropsychological correlates of depression. She is the recipient of a National Academy of Neuropsychology Clinical Research Grant to examine the relationship between inflammatory markers and cognition in multiple sclerosis.

Primary Care-Mental Health Integration (PCMHI) Rotation - Baltimore

Patient Population

The primary care clinic in Baltimore is a large, urban clinic, with approximately 27 primary care providers and 40 internal medicine residents serving 38,000 Veterans. The average age of Veterans in this clinic is 60 and the majority (90%) are male. Veterans receive care within Patient Aligned Care Teams (PACT), which are patient-centered medical homes that are structured to provide coordinated, accessible, and patient-centered healthcare. As all PC-MHI providers do, interns will function as integrated members of the PACT by providing consultation to primary care providers and the PACT teams, having availability to see patients on the day of their primary care visit, and attending and contributing to PACT team meetings.

Assessments, Treatments, & Supervision

Interns will have the opportunity to provide brief (30 min.), targeted behavioral health assessments for Veterans who are referred by their primary care team. The purpose of assessments in PC-MHI is to clarify the presenting problem and triage the Veteran to the appropriate treatment setting. Veterans who are appropriate for treatment in PC-MHI include those with common, uncomplicated presenting problems, such as depression, anxiety, tobacco use, obesity, adjustment issues, adherence problems, uncomplicated grief, and chronic pain. Most patients presenting to PC-MHI can be treated/managed within this setting. Interns will learn to tailor assessments to the particular Veteran and his or her presenting problem. Depending on patient presentation and the nature of the referral, assessments may include administration of brief measures, such as the Patient Health Questionnaire-9 (PHQ-9), Posttraumatic Stress Disorder Checklist (PCL), and Generalized Anxiety Disorder-7 item scale (GAD-7). Interns will be able to refer patients to one of several psychiatric residents who provide 20 hours of medication management per week. Interns may also have the opportunity to complete pre-transplant evaluations on this rotation.

Interns will have availability to see both scheduled patients and walk-in patients (warm hand offs) from primary care providers. Patients who are typically referred to PC-MHI include those with depression, substance use problems, PTSD, anxiety, tobacco use disorders, obesity, diabetes, chronic pain, and insomnia. Treatment in the primary care setting is brief (up to 6, 30 minute sessions) and evidence-based. Interns will utilize a wide variety of brief interventions, including behavioral activation, motivational interviewing, relaxation training, and brief CBT. Interns may have the opportunity to provide individual as well as group treatments. Group opportunities may include diabetes management group, problem-solving training group, weight management group (MOVE), pain school, depression group, and mindfulness-based stress reduction for medical conditions.

Supporting Literature

Integrated Primary Care: Integrated care can increase access to mental health care, reduce the burden on specialty mental health clinics, and modify willingness of primary care providers to address mental health concerns (Brawer, Martielli, Pye, Manwaring, & Tierney, 2010; Felker et al., 2004). It may also serve to reduce the stigma associated with mental health treatment, as a higher number of patients engage in treatment when it is integrated into primary care versus when it is delivered in specialty mental health (Bartels, 2004). Primary care providers have positive perceptions of integrated care, with the majority reporting that integrated care leads to better communication between primary care providers and mental

health providers, less stigma, better coordination of care, and better management of depression, anxiety, and alcohol problems (Gallo et al, 2004).

Brief Interventions: Interventions utilized in this setting are brief and evidence-based. When designing interventions, PC-MHI clinicians take into consideration the best available evidence along with patient characteristics and clinical expertise to develop a treatment plan that is grounded in research and also tailored to each individual Veteran's specific needs. Given the breadth of patients seen in primary care, only a review of some of the most common interventions will be discussed. Examples of common interventions include behavioral activation, brief CBT, and motivational interviewing.

Brief (4 session) primary-care based behavioral activation has been shown to reduce symptoms of both anxiety and depression in Veterans (Gros & Haren, 2011). Brief CBT has been shown to be effective in the treatment of depression and anxiety (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Nieuwsma, 2012). A recent Cochrane review found that CBT for pain has positive effects on disability, mood, and pain catastrophizing (Williams & Eccleston, 2012). Initial research suggests that brief (4-6 sessions) cognitive-behavioral treatment for PTSD in primary care may improve symptoms of PTSD and depression for younger Veterans (Cigrang et al., 2011). Brief behavioral intervention has been shown to be effective in treating insomnia (Buysse, 2011). Finally, brief motivational interviewing has been shown to reduce risky drinking behavior (Brown et al., 2010).

Supervisor's Training & Experience

Supervision will be a minimum of two hours per week, with availability for "on the spot" supervision and consultation as necessary. Outside of supervision, interns will have a variety of learning opportunities that are relevant to the primary care setting and appropriate to the level of experience and specific interests of the intern. For example, interns may shadow PACT team members (nurses, primary care providers, dieticians), present health psychology topics to primary care providers at meetings, and become familiar with relevant literature on collaborative healthcare.

Dr. Ann Brugh earned her doctorate in clinical psychology from Spalding University, with an emphasis in health psychology. Her training in integrated primary care began in graduate school with specialized classes and clinical experiences, including a year-long practicum at the Louisville VA's Behavioral Health Lab. She completed her internship at the Saint Louis VA Medical Center, with training in medical psychology and integrated primary care. She went on to complete a postdoctoral residency in Primary Care-Mental Health Integration at the Saint Louis VA, where her research and clinical work focused on chronic pain, diabetes management, and implementation of integrated healthcare. Dr. Brugh also has training and experience in providing clinical supervision. She has previously supervised both practicum students and pre-doctoral interns.

Dr. Eileen Potocki earned her doctorate in clinical psychology from the Florida State University. She completed her internship at the Johns Hopkins Health System with rotations in behavioral medicine, psychological testing, psychogeriatrics and inpatient psychiatry. Her dissertation research involved testing a biopsychosocial model of cardiovascular disease. She spent the majority of her career collocated with physicians serving the underserved and uninsured in Federally Qualified Healthcare Centers (FQHC)in the Baltimore area. Dr. Potocki held the position as Division Director of Behavioral Health at Baltimore Medical Center, Inc., a FQHC which served 50,000 internal medicine patients in multiple sites. She was an advocate for proper and judicious application of the "Integrated Care" model in a primary care environment dominated by non-psychologist providers. She has been exposed to a very large and diverse patient population. Dr. Potocki also has worked with the refugee population and is fully bilingual (Spanish).Psychosocial Rehabilitation and Recovery Center

Patient Population

The Psychosocial Rehabilitation and Recovery Center (PRRC) treats Veterans who present with a broad spectrum of psychiatric illnesses. Our population includes Veterans with schizophrenia, mood disorders, anxiety disorders including PTSD, and personality disorders. Many of the Veterans also have a co-morbid substance use disorder or substance use-related problems. The PRRC is an outpatient transitional learning center designed to support recovery and integration into meaningful self-determined community roles for Veterans challenged with severe mental illness. Referrals to PRRC are for Veterans who need additional support, education, therapy and care coordination to manage in the community. Veterans remain in the PRRC for a time limited duration per their individual needs and recovery goals and participate in daily intensive programming. Aftercare/transition plans include participation in identified groups or activities consistent with their recovery plans. Some interns on this rotation may be able to participate in activities of the Mental Health Intensive Case Management (MHICM) team. This program provides community based case management for Veterans with SMI who need intensive services and have a history of frequent or extended psychiatric hospitalizations and have been minimally responsive to the hospital based treatment.

Assessment and Intervention Training

In the PRRC, interns will be provided with training in individual, family, systems and group therapy for the treatment of serious mental illness (SMI). Group experiences can include cognitive therapy groups, social skills training (Bellack, 2004), mental health recovery groups (Frese *et al*., 2001) as well as co-leading an ACT treatment protocol for individuals with SMI (Bach & Hayes, 2002). The intern is also expected to develop and lead their own group bases on their interests and the Veteran's needs. The intern will be supervised in individual therapy including the application of cognitive therapy for treatment of SMI (Bellack, 2004; Kingdom & Turkington, 2005). Also, interns will be trained in supportive individual therapy, psychoeducation group therapy, and supportive family therapy. Interns can develop the rotation based on their interests and needs. The patient load will include 2-4 assessments, 3-4 individual psychotherapy patients in addition to co-leading at least 3 groups. Supervision will include 1-2 hours per week with Dr. Weissman and additional supervision depending on clinical activities.

Supporting Literature

The PRRC is guided by the Recovery Philosophy (Bellack, 2006) . We attempt to assist Veterans in defining and pursuing a self-determined personal vision and mission for their lives. It is the role of the clinician in the PRRC to collaborate with the Veteran to promote realization of their goals thru support, education an effective treatment. . There is support in the literature for various types of interventions, including: problem-solving skills; cognitive-behavioral therapy that includes support and education and is aimed at specific areas of deficit (*e.g.*, medication non-compliance, treatment-refractory auditory hallucinations, paranoid ideation, etc.); social skills training as a targeted treatment for social impairment; and family intervention programs that provide a combination of education about the illness, emotional support for the family, crisis intervention and motivational enhancement. (see Lehman *et al*., 2003, Schizophrenia Patient Outcomes Research Team: Updated Treatment Recommendations for a review, also Bellack, 2004). Interns will receive training in all of these interventions and more. In addition, frequent questions arise as to the accuracy of diagnosis for specific patients. A number of issues complicate the diagnostic picture, including co-morbid substance abuse, overlap with other major mental illness (*e.g*., mood disorders with psychotic features), and dementia. It is therefore important that the intern become familiar with the criteria for serious mental illnesses, including schizophrenia-spectrum disorders, bipolar disorder, and major depression, as well as substance use disorders as described in the DSM-IV.

Supervisors' Training & Experience

Dr. Jason Peer completed his Ph.D. in clinical psychology at the University of Nebraska-Lincoln where his training and research focused on psychosocial interventions for schizophrenia and related SMI. Dr. Peer completed a year-long internship with a SMI focus at the University of Maryland

Baltimore/VAMHCS Psychology Internship Consortium and a three year post-doctoral fellowship in Mental Health Research and Treatment at the VISN 5 Mental Illness Research Education and Clinical Center. In both internship and fellowship he received extensive training in CBT, skills based and psychoeducation focused interventions for SMI and substance abuse. He has been active in research and has published several peer reviewed papers related to cognitive impairment, psychosocial treatment response, vocational functioning, and substance use in SMI. He continues to collaborate with MIRECC investigators on research projects and is active in Perry Point program evaluation activities.

Dr. Neil Weissman has been an attending psychologist for the VA since 1992 and has supervised interns for these 19 years. He has completed a postdoctoral fellowship in the treatment of SMI from Sheppard Pratt and has received specialized training in CBT from the Beck Institute in Philadelphia. Dr. Weissman is also a certified supervisor in Emotionally Focused Couples Therapy from the International Center for Excellence in Emotionally Focused therapy.

Dr. Clare Gibson completed her Ph.D. in clinical psychology at the University of North Carolina at Chapel Hill where her training and research focused on social cognitive processes in schizophrenia and psychosocial interventions for individuals with serious mental illness. She completed her predoctoral clinical internship at the VAMHCS/University of Maryland Internship Consortium in the serious mental illness (SMI) track. Dr. Gibson then went on to complete a one year postdoctoral fellowship in VA's Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery (PSR) at VA Connecticut Health Care System (the Paul Errera Community Care Center) & Yale School of Medicine. Dr. Gibson's interests are in psychosocial treatments for SMI and factors related to recovery particularly internalized stigma. Her professional interests include integrating recovery into mental health systems and self-care for mental health professionals.

<u>Posttraumatic Stress Disorder Clinical Team (PCT)/Trauma Recovery Program (Outpatient Program)</u>

Patient Population

The Trauma Recovery Program (TRP) at the VAMHCS (Baltimore Division) consists of a specialized outpatient PTSD clinic that serves both male and female Veterans with a principal diagnosis of PTSD related to a variety of traumatic experiences, including combat, Military Sexual Trauma (MST), and childhood abuse. Many patients in the PCT have other co-occurring diagnoses and are active in treatment in other areas of mental health (*e.g*., Substance Abuse Treatment Program, Psychosocial Rehabilitation and Recovery Center, Mental Health Clinic). Our patient population is ethnically and racially diverse, with over 50% of patients of African-American descent. Approximately half of the patients seen in the PCT are those service members recently returning from Operations Iraqi Freedom and Enduring Freedom. We also provide a full range of clinical services for Veterans seeking services for MST.

Assessments, Treatments, & Supervision

Interns will participate in the PTSD Assessment Clinic, where he or she will conduct several intake interviews to learn gold standard methods for diagnosing PTSD. The intern will complete at least two comprehensive PTSD assessments using structured interviews, objective measures of psychopathology, and standardized self-report instruments. Comprehensive assessment skills for this rotation may include training and supervision in the use of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers *et al*., 2013), the Anxiety Disorders Interview Schedule-5 (ADIS-5; Brown & Barlow, 2014), the PTSD Checklist for DSM-5 (PCL-5; Weathers *et al*., 2013), the Mississippi Scale for Combat-Related PTSD (MISS; Keane *et al*., 1988), the Minnesota Multiphasic Personality Inventory-2-RF (Ben-Porath, 2012), and the Personality Assessment Inventory (PAI; Morey, 2007).
The rotation will consist of core training experiences involving outpatient evidence based treatments for PTSD in both individual and group formats. Interns can elect to focus on the implementation of either Cognitive Processing Therapy or Prolonged Exposure with both individual patients, as well as in group psychotherapy. Interns also have the opportunity to learn Cognitive Behavioral Therapy for Insomnia

(CBT-I), Motivational Interviewing (MI), Acceptance and Commitment Therapy for PTSD (ACT), Stress Inoculation Training (SIT), Seeking Safety, Dialectical Behavior Therapy (DBT), and Skills Training in Affective and Interpersonal Regulation (STAIR). Elective experiences and minor rotations will be selected to round out the training plan for each intern.

The patient load will include two to four individual psychotherapy patients in addition to co-leading one to two outpatient groups. Interns will also conduct both brief unstructured interviews and comprehensive psychological assessments in the PTSD Assessment Clinic, to meet the Consortium requirements for assessment. Interns will receive at least two hours of individual supervision each week with a clinical psychologist listed below in order to review cases, provide further assessment and intervention training, and establish concrete treatment plans for group and individual patients. Additional supervision will be provided by other TRP staff psychologists, with several additional opportunities for group supervision available each week. Supervisors in the PTSD Clinical Team frequently highly value the use of audio and visual recordings in supervision, and often use this method to assist in guidance in the implementation of evidence based treatments for PTSD.

Interns will participate in a number of training opportunities during the rotation, including monthly didactics, interdisciplinary treatment team meetings, and EBP consultation group. Interns who match with the Trauma Recovery Program (APPIC # 134719) often participate in a three-day Cognitive Processing Therapy training, with six months of consultation, from a VA national rollout trainer (Dr. A. Santanello). Monthly didactic seminars will focus on the applied learning and practice of empirically supported treatments, assessment, administration, research and professional development (e.g., supervision) within the field of trauma work (See below for the 2015-2016 seminar schedule). An EBP consultation groups focused on the delivery of Prolonged Exposure and Cognitive Processing Therapy are also offered to trainees at all levels. Finally, the TRP has an extensive library of resources, including articles, manuals, and training videos that are available to interns.

Supporting Literature

Exposure therapy (ET; Foa *et al*., 1991; Keane *et al*., 1989) has been consistently demonstrated as an effective treatment for addressing specific traumatic memories; this approach has been endorsed by the Division 12 Task Force as an efficacious treatment for PTSD. Cognitive therapy (CT), Imagery Rehearsal Therapy (IRT) and Stress Inoculation Training (SIT) have consistently shown high rates of efficacy for symptoms reduction as well, and all four treatments have been adopted as best clinical practices by the VA/DoD Clinical Practice Guidelines (VA/DoD Clinical Practice Guideline, Management of Posttraumatic Stress, 2010). Additionally, the use of anxiety management training has been empirically supported in the PTSD and other anxiety research literature (Foa *et al*., 2000). Although there is limited evidence surrounding efficacious treatment for dual-diagnostic patients with PTSD and substance use disorders, the Seeking Safety protocol (Najavits, 2002) has demonstrated promising longitudinal outcome data. While preliminary studies were limited to small sample sizes, and few addressed Veteran populations, more recent studies include larger samples and a variety of Veteran populations. Coping skills that are part of the Seeking Safety program are similar in content to anxiety management training and make an important link between PTSD and substance abuse/dependence.

In addition to the above-mentioned interventions, interns will be learning specific coping skills from Dialectical Behavior Therapy (DBT), which was originally designed for the treatment of borderline personality disorder but which can be applied to other patient populations (Linehan, 1993); principles of Acceptance and Commitment Therapy (ACT) as it applies to PTSD (Batten, Orsillo, & Walser, 2005; Hayes *et al*., 1999); relaxation procedures, including progressive muscle relaxation and guided imagery; and other cognitive-behavioral approaches, including skills such as cognitive reframing and behavioral activation (Foa *et al*., 2000).

Related to PTSD assessment, the CAPS has been shown to have excellent reliability and validity (convergent and discriminative validity) within trauma populations; it is considered the “gold standard” of interviews for

PTSD (Weathers *et al*., 2001). The PCL (*e.g.*, Ruggiero *et al*., 2003) and MISS (*e.g*., Norris *et al*., 1996), both symptom self-report measures, have demonstrated utility in the assessment and diagnosis of PTSD, with good evidence for reliability and validity. Finally, the BDI and BAI are commonly used self-report measures that involve a general assessment of depressive and anxiety symptoms, useful as adjunct data in the comprehensive assessments of Veterans and for detection of possible co-occurring diagnoses. A comprehensive review of assessment procedures for trauma and PTSD can be found in *Assessing Psychological Trauma and PTSD* (Wilson & Keane, 2004).

Supervisors' Training & Experience

Interns' individual therapy will be supervised by one of the psychologists in the Trauma Recovery Program. The TRP staff has received extensive training in the use of exposure therapy and other above-mentioned interventions through graduate school education, internship training, postdoctoral training, and specific workshops and training experiences that have enhanced their knowledge and expertise in the treatment of PTSD. Trauma psychologists will conduct one hour of peer consultation per week to maintain proficiency in evidence-based practices for PTSD.

Melissa Decker Barone, Psy.D. is the Director of the Postdoctoral Fellowship, and a Staff Psychologist in the PTSD Outpatient Team. She served as the Director of Training for the VAMHCS/UMB Psychology Internship Consortium from 2010-2015. She completed a psychology internship and postdoctoral fellowship in the Trauma Recovery Program at the VA Maryland Health Care System. She received supervision and training in empirically supported treatments for PTSD, as well as co-morbid PTSD and substance use, medical illness, and health behavior change. She has trained with Drs. Foa and Hembree to become a certified Prolonged Exposure consultant for the VA National Rollout Trainings. Dr. Barone has received training in Acceptance and Commitment Therapy (ACT), CPT, PE and DBT over the course of her graduate studies, and her doctoral dissertation investigated the role of worry in experiential avoidance. Her research interests include treatment outcome research for empirically supported treatments for PTSD, as well as the relationship between PTSD and comorbid health concerns. Dr. Barone was honored to be the recipient of the Outstanding Supervisor Award, awarded by the 2009-2010 VA/UMB Internship Consortium class, and Outstanding Director of Training in 2014.

Sara Nett, Psy.D is the MST Coordinator for the VAMHCS. She completed her graduate training in Clinical Psychology at Indiana State University. She completed an integrated postdoctoral fellowship in trauma recovery and traumatic brain injury at the VA Maryland Health Care System, following the completion of a predoctoral internship at the Salem VA Medical Center. Dr. Nett has received training in a variety of evidence based treatments for trauma and comorbid substance use disorders, including Acceptance and Commitment Therapy, Prolonged Exposure Therapy, Cognitive Processing Therapy, Dialectical Behavior Therapy, and Seeking Safety. Her clinical and research interests include the use of evidence based treatments for Posttraumatic Stress Disorder, the role of experiential avoidance in maintaining symptoms of PTSD, treatment of sexual trauma, and treatment of personality disorders.

Dave O'Connor, Ph.D. earned his graduate degree in Clinical Psychology at the Florida State University in Tallahassee Florida. He completed his internship at the Baltimore VAMHCS in 2002 with specialized training in the assessment and treatment of substance use disorders (SUD), neuropsychological assessment, and medical psychology. Dr. O'Connor was hired here after internship and provided general assessment, individual and group SUD treatment, and student training in the Opiate Agonist Treatment Program. During this work he developed an interest in the treatment of co-morbid SUD and PTSD and was very excited in 2009 to accept the position of Addiction Psychologist assigned to the Trauma Recovery Program in which, he focuses on providing care to this dual diagnosis population. Dr. O'Connor has received training in Motivational Enhancement, Prolonged Exposure, Cognitive Processing Therapy, and Relapse Prevention. Provision of and training in psychological assessment has always been one of Dr. O'Connor's areas of interest and he served on the Training Committee as Assessment Coordinator for the VA/UMB Internship Consortium from 2009-2015. He was highly gratified to be the

recipient of the Outstanding Supervisor Award, awarded by the 2008-2009 VA/UMB Internship Consortium class.

Erin Romero, Ph.D. received her doctoral degree from Northwestern University Feinberg School of Medicine, Department of Psychiatry and Behavioral Sciences, Division of Psychology. She completed a psychology predoctoral internship at the VA Maryland Health Care System (VAMHC) and obtained specialized training in substance use, serious mental illness, and PTSD. She received further specialized training in PTSD during her integrated postdoctoral fellowship in traumatic brain injury and PTSD in returning Veterans at the VAMHC. Dr. Romero has received training in a variety of treatment models, including Motivational Interviewing, Acceptance and Commitment Therapy, Prolonged Exposure Therapy, Cognitive Processing Therapy, Virtual Reality Exposure Treatment, Seeking Safety, Dialectical Behavior Therapy, Wellness Recovery Action Planning, and Social Skills Training. Dr. Romero's research has focused on racial/ethnic health disparities. Her research on the mental health needs and HIV/AIDS risk behaviors of delinquent youth has resulted in multiple peer-reviewed publications and conference presentations. Dr. Romero has increasingly become interested in program evaluation and in barriers to treatment in returning Veterans. Dr. Romero is the Trauma Recovery Program Coordinator.

Andrew Santanello, Psy.D. completed a psychology internship and a post-doctoral fellowship at the Baltimore VAMC and is a licensed psychologist in Maryland. He has received training in Acceptance and Commitment Therapy, Prolonged Exposure Therapy (PE), and Cognitive Processing Therapy (CPT) and is listed on VA national rosters of certified clinicians for both PE and CPT. In addition to empirically-based psychotherapies for Posttraumatic Stress Disorder (PTSD), Dr. Santanello has a strong interest in mindfulness-based psychotherapy. He has served Maryland's Veterans in various roles and locations within the VA Maryland Health Care System (VAMHCS) in the past including Addictions/Trauma specialist for the PTSD Clinical Team at the Perry Point VA Medical Center and Local Evidenced-Based Psychotherapy Coordinator for both the Baltimore and Perry Point VA Medical Centers. Currently, Dr. Santanello is the Coordinator for the Services for Returning Veterans Mental Health Program (SeRV-MH). The SeRV-MH program focuses on treatment engagement (including outreach), consultation/crisis management and providing evidenced based treatment for returning Veterans from the OEF/OIF wars and other combat areas that are part of the Global War on Terrorism.

Erika White, Ph.D. completed her graduate education at Saint Louis University. She completed a pre-doctoral internship at the Washington, D.C. VAMC and a postdoctoral fellowship in trauma at the Pittsburgh VAMC. Her dissertation research focused on the effects of racial microaggressions and colorblindness on the working alliance of cross-racial counseling dyads. Dr. White is trained in Cognitive Processing Therapy and Prolonged Exposure. In August 2011, Dr. White was hired as a staff psychologist in the Trauma Recovery Program (TRP) at the Baltimore VAMC. Dr. White joined the Training Committee for the VAMHCS/UM Psychology Internship Consortium in 2012. In 2013, Dr. White assumed the role of Team Leader in the PTSD Clinical Team (PCT). In this role, she serves as coordinator for the PTSD Assessment Clinic, manages referrals for the PCT, and conducts treatment planning sessions with Veterans. Also in 2013, Dr. White was ecstatic to be selected as the Outstanding Supervisor of the Year by the intern class.

PTSD Residential Rehabilitation Treatment Program (RRTP)

Patient Population

The Residential Rehabilitation Treatment Program (RRTP) consists of a specialized residential dual diagnosis unit that serves both male and female Veterans with a principal diagnosis of PTSD and Substance Use Disorder. The RRTP is a ten-bed, mixed gender, mixed trauma (military stressors, MVAs, childhood sexual abuse, MST, etc) unit. Veterans attend programming for both PTSD and SUD for approximately 6-8 weeks. Our patient population is ethnically and racially diverse, with over 50% of patients of African-American descent. An increasing number of the patients seen are those service

members recently returning from Operations Iraqi Freedom and Enduring Freedom, as well as Veterans seeking services for Military Sexual Trauma (MST).

Assessments, Treatments, & Supervision

Interns will participate in the PTSD Assessment Clinic, where he or she will conduct several intake interviews to learn appropriate methods for diagnosing PTSD. The intern will complete at least two full-scale comprehensive PTSD assessments using semi-structured interviews, personality assessment, and standardized self-report instruments. Comprehensive assessment skills for this rotation will include training and supervision in the use of the Clinician-Administered PTSD Scale (CAPS; Blake *et al*., 1995) and the Anxiety Disorders Interview Schedule (ADIS), the PTSD Checklist (PCL; Blanchard *et al*., 1996), the Mississippi Scale for Combat-Related PTSD (MISS; Keane *et al*., 1988), the Minnesota Multiphasic Personality Inventory-2 (Butcher *et al*., 1989), the Beck Depression Inventory (Beck *et al*., 1961), and the Beck Anxiety Inventory (Beck & Steer, 1990).

The rotation will consist of core training experiences involving group therapies and individual treatment. Interns will have opportunities, depending on interest and patient preferences, to receive supervision in the two modes of treatment for PTSD with the most empirical support: exposure therapy and cognitive processing therapy. They will also receive specific training in approaches to the treatment of dually-diagnosed Veterans with PTSD and substance use disorders, including Seeking Safety, as well as interventions based in mindfulness and Dialectical Behavior Therapy.

The patient load will include one to two individual psychotherapy patients in addition to co-leading one to two outpatient groups. Interns will receive at least two hours of individual supervision each week with a clinical psychologist listed below in order to review cases, provide further assessment and intervention training, and establish concrete treatment plans for group and individual patients. Additional supervision will be provided by other TRP staff psychologists, with several additional opportunities for group supervision available each week.

The patient load will include one to two individual psychotherapy patients in addition to co-leading one to two outpatient groups. Interns will receive at least two hours of individual supervision each week with a clinical psychologist listed below in order to review cases, provide further assessment and intervention training, and establish concrete treatment plans for group and individual patients. Additional supervision will be provided by other TRP staff psychologists, with several additional opportunities for group supervision available each week.

Interns may have opportunities to participate in a number of training opportunities during the rotation, including monthly didactics, a process group and consultation groups. Monthly didactic seminars will focus on the applied learning and practice of empirically supported treatments, assessment administration, research and professional development (e.g., supervision) within the field of trauma work. Consultation groups focused on the delivery of Prolonged Exposure and Dialectical Behavior Therapy are also offered to trainees at all levels. Drs. Nett and O'Connor also facilitate a process group for staff and trainees, focused on discussing how working within the field of PTSD can impact one's self care and work with patients. Finally, the TRP has an extensive library of resources, including articles, manuals, and training videos that are available to interns.

Supporting Literature

Exposure therapy (ET; Foa *et al*., 1991; Keane *et al*., 1989) has been consistently demonstrated as an effective treatment for addressing specific traumatic memories; this approach has been endorsed by the Division 12 Task Force as an efficacious treatment for PTSD. Cognitive therapy (CT), Imagery Rehearsal Therapy (IRT) and Stress Inoculation Training (SIT) have consistently shown high rates of efficacy for symptoms reduction as well, and all four treatments have been adopted as best clinical practices by the VA/DoD Clinical Practice Guidelines (VA/DoD Clinical Practice Guideline, Management of Posttraumatic Stress, 2010). Additionally, the use of anxiety management training has been empirically supported in the PTSD and other anxiety research literature (Foa *et al*., 2000).

In addition to the above-mentioned interventions, interns will be learning specific coping skills from Dialectical Behavior Therapy (DBT), which was originally designed for the treatment of borderline personality disorder but which can be applied to other patient populations (Linehan, 1993); principles of Acceptance and Commitment Therapy (ACT) as it applies to PTSD (Batten, Orsillo, & Walser, 2005; Hayes *et al*., 1999); relaxation procedures, including progressive muscle relaxation and guided imagery; and other cognitive-behavioral approaches, including skills such as cognitive reframing and behavioral activation (Foa *et al*., 2000).

Related to PTSD assessment, the CAPS has been shown to have excellent reliability and validity (convergent and discriminative validity) within trauma populations; it is considered the "gold standard" of interviews for PTSD (Weathers *et al*., 2001). The PCL (*e.g.*, Ruggiero *et al*., 2003) and MISS (*e.g*., Norris *et al*., 1996), both symptom self-report measures, have demonstrated utility in the assessment and diagnosis of PTSD, with good evidence for reliability and validity. Finally, the BDI and BAI are commonly used self-report measures that involve a general assessment of depressive and anxiety symptoms, useful as adjunct data in the comprehensive assessments of Veterans and for detection of possible co-occurring diagnoses. A comprehensive review of assessment procedures for trauma and PTSD can be found in *Assessing Psychological Trauma and PTSD* (Wilson & Keane, 2004).

Supervisors' Training & Experience

Erin E. Burns, Ph.D. is a Staff Psychologist in the PTSD Dual Diagnosis Residential Rehabilitation Treatment Program. She received her doctoral degree in Clinical Psychology from the University of Georgia, completed her pre-doctoral internship at the Atlanta VAMC, and her postdoctoral fellowship in PTSD at the VA Palo Alto Health Care System. In addition to training in Prolonged Exposure (PE) under the supervision of Dr. Barbara Rothbaum, she is a VA certified provider of Cognitive Processing Therapy (CPT). Dr. Burns has also received training and supervision in Dialectical Behavior Therapy, Acceptance and Commitment Therapy, and STAIR (Skills Training in Affective and Interpersonal Regulation). While in graduate school, Dr. Burns' research was broadly focused on the sequelae of child maltreatment, with an emphasis on identifying mechanisms that contribute to the distal association between abuse and psychopathology. Specific research projects examined several mediating variables including emotion regulation, attachment, and early maladaptive schemas. More recent clinical interests include treatment of moral injury and the use of a stage-based approach to target symptomatology associated with complex PTSD.

Josh Semiatin, Ph.D earned his doctorate in clinical psychology from the University of Maryland, Baltimore County. He completed his pre-doctoral internship at the Albuquerque VA Medical Center, with an emphasis on Evidence Based Therapies for PTSD and dual diagnosis, couple therapies, and assessment. Dr. Semiatin also completed a two-year clinical practicum at Advocates for Survivors of Torture and Trauma, a non-profit clinic in Baltimore focused on PTSD recovery among asylum-seeking immigrants. Prior to joining VA Maryland, Dr. Semiatin served as staff psychologist in the VA Pittsburgh's Combat Stress Recovery Clinic. His clinical interests include CBT for PTSD, Acceptance and Commitment Therapy, conjoint/couples treatments for Veterans with trauma histories, anger and aggression, diversity issues in psychotherapy, and psychological assessment. His research has focused on the impacts of trauma and PTSD on anger and aggression, particularly intimate partner violence (IPV) and childhood physical abuse. His publications include scientific articles related to violence prevention, as well as a book chapter on motivational interviewing for partner-violent men, and he has presented symposia at national research conferences, including those of the Association of Behavioral and Cognitive Therapies and the Pediatric Academic Societies.

Elizabeth Malouf PhD completed a psychology internship in the Comprehensive Track at the Baltimore VAMC and worked as a postdoctoral fellow in VAMHCS's Trauma Recovery Program. Throughout her career, she has focused on cognitive behavioral and mindfulness-based treatment for substance use disorder and PTSD. She has experience treating substance use disorder with Motivational Interviewing

(MI), Motivational Enhancement Therapy (MET), Mindfulness Based Relapse Prevention (MBRP), and Acceptance and Commitment Therapy (ACT). She has received training in Prolonged Exposure Therapy (PE) and is a VA certified provider of Cognitive Processing Therapy (CPT). She has research and clinical interest in the role of impulsivity and emotional dysregulation in psychopathology as well as the potential for mindfulness-based interventions to improve these important factors. She completed her graduate training at George Mason University where she conducted grant funded research on clinical interventions for substance use disorder in jail inmates.

Telemental Health Rotation

General

The Rural Health via Telemental Health Minor Rotation within VAMHCS consists of specialized training in the knowledge and skills necessary to serve distally located patients via innovative treatment modalities such as Clinical Video Telehealth. The rotation is designed to prepare students to serve medically underserved patients who reside outside of major urban areas and would benefit from access to evidence based treatment. Interns are encouraged to become familiar with unique treatment needs and necessary skills for evidence based treatment delivery to these populations. Telehealth equipment will be provided (e.g., MOVI camera and software) to intern serving in this rotation at their Baltimore office and at their one-day per week CBOC site (Glen Burnie or Loch Raven).

Patient Population

The primary setting for this rotation is virtual. While stationed at Baltimore, the psychology intern will meet with Veterans in the Tele Mental Health (TMH) program. Therapy sessions will occur via video teleconference to several possible VA Community-based Outpatient Clinics (CBOC): 1) the Cambridge CBOC; 2) the Pocomoke CBOC, both located on the Eastern Shore of Maryland, 3) the Glen Burnie CBOC, 4) the Loch Raven CBOC, and 5) the Ft. Howard CBOC, located outside of Baltimore. The CBOCs are staffed by psychologists, psychiatrists, medical and mental health social workers, physicians, nurse practitioners, and pharmacists. Mental Health services are integrated into the primary care clinic. The role of the supervising psychologists within the TMH program is to provide Specialty Mental Healthcare related to PTSD, MDD, SUDS, SUDS/PTSD, and in addition, the intern may also have the opportunity to work with patients struggling with more general mental health conditions. This rotation affords interns the opportunity to work as part of an integrated healthcare team, directly interacting with both primary and mental healthcare providers, as well as staff specifically designated to TMH services.

Veterans seeking care at the VA CBOCs are generally high functioning, motivated and employed or retired. Interns will have the opportunity to work with both male and female Veterans, who live in a rural setting and who have mental health issues that are sometimes exacerbated by issues associated with rural living. The Veterans are generally 18 and older and varied in their ethnic and racial backgrounds. Interns can expect to gain experience with a variety of diagnostic and treatment issues, including PTSD, MDD, Anxiety, Bipolar Disorder, and Substance Use Disorders (the most common substances of abuse among these Veterans includes alcohol, marijuana, prescription drugs, and some use of cocaine and heroin. Actively psychotic and/or suicidal Veterans are not generally seen via TMH. However, in the event that a patient becomes suicidal, support staff and licensed providers on the patient side are readily available to assist with emergencies.

Supervision, Training, and Location

In line with APA standards for supervision, interns will be provided with one hour per week of face-to-face supervision and one hour per week of supervision by teleconference. Choice of primary supervisor will determine intern location in order to support face-to-face supervision. All interns will be primarily located in Baltimore with one day per week located at their supervisor's site. Interns working with Dr. Aspnes or Dr. Smith will be stationed at Glen Burnie CBOC one day per week and interns working with Dr. Cotton will be stationed at Loch Raven CBOC one day per. Choice of primary supervisor will be decided in consultation with the intern based on matching their interests with the expertise of the primary

supervisor. Group supervision will also be provided for one hour per week via teleconferencing, which will increase familiarity with TMH equipment and effective treatment delivery using this modality. Interns will also be encouraged to make site visits to rural clinics they serve within the rotation, such as Cambridge, Pocomoke, Fort Howard, or Charlotte Hall in the company of their primary supervisor who can secure a government vehicle and provide transportation during work hours to the rural site.

Interns will also be provided with approximately three hours of mandatory online training via Talent Management System (TMS) in conducting TMH. These trainings provide practical knowledge and problem-solving specific to TMH modality. At the end of these trainings, they will be asked to complete a skills assessment with a national TMH specialist, which is the final step to be registered as a TMH provider. This is a designation and skill set that is maintained across VA sites.

Assessments and Treatment

During this rotation, interns will function as an integral part of a TMH team, which includes the attending prescriber, the supervising psychologist, the TMH psych tech, and the TMH health tech. The intern will serve as the primary therapist using evidence-based cognitive behavioral therapies (CBT). Training and supervision may include didactics and hands-on exposure to the following evidenced-based therapies:

a. The basics of the TMH modality, including the TMS training that is required prior to providing TMH services.
b. The essentials of Cognitive Behavioral Treatment (Beck, A., 1979; Beck, J., 1995;)
c. The fundamentals of the Motivational Interviewing approach to treating addictions (MET; Miller and Rollnick, 1991), particularly as it applies to the phase of change model of motivation (Prochaska, Diclemente, and Norcorss, 1992).
d. The tenets of exposure-based therapies for the treatment of PTSD and other anxiety disorders, including the use of Prolonged Exposure Therapy via TMH (Foa, Hembree, Rothbaum, 2007; Craske and Barlow, 2007)
e. The fundamentals of Seeking Safety therapy for the concurrent treatment of PTSD/SUDS (Najavits, L., 2002)
f. The use of Mindfulness approaches to treat depression, anxiety, and other mental health disorders (Segal, Williams, Teasdale, 2002; Linehan, 1993; Hayes, 2005).

Interns will have the opportunity to complete a 4 month-long rotation in the TMH major rotation. Interns will carry an individual patient caseload, and possibly conduct group therapy via TMH as the TMH program expands (currently there are no TMH groups). Interns will conduct full psychosocial assessments to include the diagnosis of and differentiation between moderate and severe substance use disorders; the distinctions between PTSD, GAD, Depression, other Anxiety Disorders, and TBI; and differentiate and understand co-morbidity and the need for concurrent treatment of substance use disorders, PTSD, mood disorders and other psychiatric disorders. Interns will use assessment tools such as brief screening tools, self-report symptom measures, semi-structured diagnostic interviewing (e.g., Clinician Administered PTSD Scale for DSM-5), and personality testing where appropriate.

Supporting Literature

The majority of our nation's Veterans are from rural areas, where patients may have to drive long distances to meet with a mental health provider. In the VA, Telemental health (TMH) is an increasingly common mode of delivering treatment, and has been shown to be effective (Shore et al., 2012). Studies to date are promising, and have shown no significant differences in patients' perceptions of the therapeutic alliance, treatment outcomes as evidenced by PCL-S and BDI-II scores, or overall satisfaction with services when telemental health and face-to-face modalities are compared (Morgan, Patrick, Amber and Magaletta, 2008). Additionally, providing evidenced-based therapy via Telemental health to combat Veterans in a rural setting has been shown to be practicable and to produce outcomes that are as good as in-person delivery of the same treatment (Morland, Greene, Rosen, Foy, Reilly, Shore, He, and Frueh, 2010).

Supervisor's Training and Experience

Garnette J. Cotton, Ph.D. is a Veteran's Integrated Service Network (VISN) Psychologist for VA Maryland Health Care System providing access to evidence based, cognitive behavioral therapy to a highly traumatized population of male and female United States Veterans with concurrent medical and co-occuring psychosocial problems via Telemental Health. She previously served as Assistant Clinical Professor at University of California San Francisco focusing on the innovative treatment of medically underserved urban and incarcerated patients and the training of psychology interns and fellows in cognitive behavioral therapy for UCSF's psychology internship program. In 2011, in an effort to expand access to medically underserved rural patients, Dr. Cotton joined VA Northern California Health Care System where she was tasked with the expansion of evidence based treatment via Clinical Video Telehealth. Dr. Cotton completed her post-doctoral training at the San Francisco VA Medical Center specializing in PTSD and Substance Use Disorders, and her internship training at VA Palo Alto Health Care System specializing in Behavioral Medicine. She has served as a national and local expert on the treatment of medically underserved patient populations, including incarcerated patients, via Telemental health. Her research interests include the use of alcohol and substances in ethnic minority populations, and her clinical interests include evidence based treatment modalities and culturally competent treatment provision. She was the recipient in 2008 of the University of California San Francisco, Department of Psychiatry, David Rea Teaching and Training award for the training of psychology interns and fellows.

Ann E. Smith, Psy.D is a clinical psychologist at the Cambridge CBOC, where she supervises an ongoing PTSD/SUDS externship program, which includes opportunities for externs to participate in TMH. Prior to joining the VAMHCS, Dr. Smith was the PTSD/SUDS specialist at the Bronx VA, in New York City. She developed the Integrated Recovery Services program, designed to provide concurrent treatment for Veterans with both disorders. Dr. Smith was part of the PTSD research team, and also taught and supervised psychology interns in the Bronx VA internship training program. Previously, Dr. Smith was a Senior Psychologist at the North Bronx Healthcare Network, and a clinical supervisor in the Growth and Recovery Program. She led a year-long experiential psychotherapy seminar that was an integral part of the psychology internship training program. She was formerly a thesis advisor for Pratt Institute in New York City, and on faculty at New School University and the Institutes for the Arts in Psychotherapy. Dr. Smith received her doctorate at Fielding Graduate University and completed her doctoral internship at Columbia Presbyterian Medical Center in Manhattan, where she fulfilled a year-long rotation in Dialectical Behavior Therapy (DBT). As part of her ongoing training as a psychologist, she has trained in Prolonged Exposure Therapy, Mindfulness-based Cognitive Therapy, and Motivational Interviewing. Additionally, she incorporates other evidence based therapies into her work with Veterans, such as CBT-I, Cognitive Processing Therapy and Seeking Safety.

Clinical Rotations – Perry Point VA Medical Center

<u>Gero-neuropsychology – Community Living Center</u>

Patient Population

The primary training site for interns is the community living center (CLC) at the Perry Point VAMC. Residents are males, 55 and older, who have varied ethnic and racial backgrounds with the majority being Caucasian and African American. Interns would occasionally have an opportunity to provide services to some younger residents (twenty-five to fifty-years old). A majority of the residents present with mild to severe cognitive impairment secondary to a variety of conditions, including degenerative neurological disease, cerebrovascular disease, metabolic conditions, nutritional deficiencies and traumatic brain injury. In addition, approximately half of the residents have a history of serious and chronic psychiatric conditions in addition to their medical issues. The types of co-existing psychiatric problems include depression, anxiety, PTSD, schizophrenia, schizoaffective disorder, bipolar disorder, and substance use disorder. Other psychological problems that are often presented include grief and bereavement, pain

disorder and adjustment disorders. The intern may have the opportunity to work with residents who have terminal illnesses and/or their families.

Assessments, Treatments, & Supervision

During the CLC gero-neuropsychology rotation, interns will function as an integral part of a medical inpatient, inter-disciplinary team (IDT), which includes the attending physician, social worker, chaplain, occupational and recreational therapist and nursing staff. In this role, the intern will also provide support for the CLC cultural transformation change process by providing consultation and in-service training to unit staff and by participating in activities to create a home-like atmosphere in the CLC neighborhoods (i.e., units). The intern will be expected to attend weekly IDT meetings, address consults for assessments as requested by the attending physician, carry a caseload of residents for individual psychotherapy and provide consultation to the IDT and nursing staff for residents who present with challenging and disruptive behaviors.

Interns will conduct cognitive and mood screenings for a minimum of twelve residents to assist in making recommendations for additional assessment and/or mental health intervention. These cognitive and mood screenings will consist of a formal mental status examination (e.g, MMSE, SLUMS, Mini-cog), the Clock Drawing Test, the Geriatric Depression Scale –Short-Form and/or the VA clinical reminder screening tools. In addition, it is anticipated that interns will conduct more in depth neuropsychological assessments for another four residents with an emphasis on evaluating their decision-making capacity and developing recommendations to assist with discharge planning. These neuropsychological assessments will utilize a flexible battery approach with the specific instruments being selected to most efficiently answer the referral question and which are most appropriate in consideration of the resident's age, language and sensory-motor functioning. The intern will be provided supervision and practice administering, scoring and interpreting the various instruments that are used while ensuring adherence to the APA Guidelines with regard to assessing older adults (APA 2008; Knight et.al., 1995).

Interns will also provide individual psychotherapy and/or behavioral intervention consultation to interdisciplinary treatment teams for six to eight residents addressing a variety of issues that may include psychosis, mood and anxiety disorders, adjustment disorders and bereavement as well as disruptive behaviors secondary to cognitive impairment. The psychotherapeutic intervention training/supervision will focus on case conceptualization and treatment utilizing a cognitive-behavioral model. Specifically, interns will be exposed to the CBT literature addressing anxiety, depression and pain management as well as the application of this approach to working with older adults and in long-term care environments (Gallagher-Thompson and Thompson 2009; Knight et.al., 1995; Laidlaw, et al 2003; Meeks & Depp, 2003; Meeks & Teri, 2004). In addition, the intern will provide both formal and informal consultation services to the IDT and nursing staff to assist in the identification and implementation of behavioral/environmental interventions in order to address challenging and disruptive behaviors being displayed by residents (Attix and Welsh-Bohmer, 2006; Conn et al., 2007;Meeks & Teri, 2004; Nordhus et al., 1998). The PPVAMC is one of the STAR-VA pilot sites for implementation of an evidence-based approach to addressing disruptive behaviors secondary to dementia. The intern will be provided training and gain experience in implementing the STAR-VA approach to managing challenging behaviors.

Interns may choose either a major or minor rotation in CLC gero-neuropsychology as is consistent with their level of career interest. The intern will be provided a minimum of two hours of face-to-face individual supervision. However, it is anticipated that additional supervision will be provided, as needed, based on the intern's level of experience.

Supporting Literature

Long-term care settings are currently undergoing a cultural transformation designed to transition the nursing home care environment from that of an institutionalized medical model to a more home-like

environment that is focused on client-centered service delivery (Baker, 2007; Thomas, 2007). Psychologists can play a pivotal role in supporting this change process through direct services to residents as well as by providing indirect support to long-term care staff (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Knight et.al., 1995; Nordhus et al., 1998). Specifically, individual cognitive and behavioral interventions have demonstrated efficacy in addressing the psychiatric issues which are often presented in long-term care settings, such as mood disorders, depression, anxiety, and pain management (Gallagher-Thompson and Thompson 2009; Karel et al., 2002; Knight et.al., 1995; Laidlaw, et al, 2003; Meeks & Depp, 2003; Meeks & Teri, 2004). In addition, literature has shown that the provision of proactive behavioral and environmental mental health services to residents with dementia can be effective in addressing challenging and disruptive behaviors (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Nordhus et al., 1998). As a result, the reliance on psychotropic medications can be reduced; thus decreasing the risk of detrimental side effects, including shortened life span (Knight et.al., 1995).
The use of neuropsychological assessment with the elderly as applied to decision-making capacity and discharge planning is growing (APA 2008; Attix and Welsh-Bohmer, 2006). Interns will be encouraged to gain familiarity with the literature addressing differential diagnosis and clinical and neuropsychological presentations of delirium, psychiatric disorders, mild cognitive impairment and various dementia syndromes (APA, 2008; Attix & Welsh-Bohmer 2006; Lezak et al., 2004; Ricker, 2004; Storandt & VandenBos, 1994).

Supervisor's Training and Experience

Dr. Jodi L. French earned her doctorate in clinical psychology from the Virginia Consortium for Clinical Psychology in 1991. She completed a major rotation in gero-neuropsychology during her predoctoral internship at the Perry Point VAMC, which she completed in 1990. Dr. French also completed a two-year postdoctoral residency in clinical neuropsychology at the Fielding University in 1998. In addition, she worked as a consultant psychologist to community nursing homes and assisted living facilities in Virginia and Florida from 1995 to 1998. Since then, Dr. French has provided outpatient mental health services to aging adults and their families and caregivers in a private practice setting. In May 2008, she was appointed to the newly created CLC Clinical Psychologist position for the Perry Point VAMC and has been providing services to over 100 CLC residents living in at least four different long-term care neighborhoods (units). In addition, she has received training in the evidenced-based STAR-VA approach for addressing challenging and disruptive behaviors due to dementia that are displayed by residents in community living centers. Dr. French has specialized Neuropsychology privileges and has conducted outpatient neuropsychological assessments in a private practice setting since 1998.

Psychosocial Rehabilitation and Recovery Center – Perry Point

Patient Population

The Perry Point Psychosocial Rehabilitation and Recovery Center (PRRC) serves Veterans with serious mental illness (SMI) including schizophrenia, affective disorders, and some severe forms of anxiety disorders. A portion of PRRC Veterans have a co-occurring substance use disorder which may also be a focus of treatment. Veterans served by the PRRC typically experience a range of functional limitations. The majority of Veterans are male and ages range from 20s to 70s.

Assessments, Treatments, and Supervision
PRRCs represent one of VA's many efforts to implement the goals of the President's New Freedom Commission on Mental Health including the principle that mental health care should be individualized and recovery focused. As such, PRRCs offer a daily menu of treatment alternatives with sufficient variety to support meaningful choice. Veterans are encouraged to set personally relevant recovery goals and select the groups and classes that will assist them with meeting these goals. As part of these treatment choices PRRC's are tasked with providing evidence-based interventions designed for the SMI population.

The intern will receive training in the following SMI focused interventions: social skills training and cognitive behavior therapy (CBT). The latter delivered in either group based or individual formats. The intern will also co-lead Illness Management and Recovery (IMR) psychoeducation, co-occurring disorder groups and mindfulness based interventions. The intern will see 3-4 individual psychotherapy cases and co-lead groups with their supervisor. There will be additional opportunities to co-lead similar groups (anger management, co-occurring disorders etc.) through the Perry Point campus wide *Recovery Center* (see description below). In addition to delivering these evidence based interventions the intern will provide case management to Veterans participating in PRRC. As part of case management interns will collaborate with Veterans in identifying personal recovery goals. These goals inform the Veteran's individualized treatment plan and how the program is tailored to their needs. The intern will also participate on the PRRC interdisciplinary treatment team. With regard to assessment, interns will have the opportunity to use standard psychological assessment measures such as the WAIS, WMS, PAI and MMPI as well as more brief screening instruments (e.g., RBANS) in order to inform treatment planning for certain cases. Finally, the PRRC rotation offers the intern the opportunity to learn about a recovery focused approach to mental health.

Supporting Literature

As reviewed above, the PRRC is tasked with delivering evidence based interventions for SMI. Social skills training, CBT, and treatments for co-occurring disorders among others are recommended interventions for schizophrenia (Dixon et al., 2010). There is strong support for use of social skills training for individuals with schizophrenia and related SMI (Kurtz & Mueser, 2008). This modality uses behaviorally-based instruction, modeling, rehearsal, corrective feedback, and positive reinforcement to teach a variety of interpersonal skills. Many Veterans served by the PRRC, while not in an acute phase of illness, still experience depressive and anxiety symptoms and have been able to learn and benefit from CBT strategies. The evidence base for CBT for depression and anxiety is substantial including support for use of group based CBT interventions. The evidence base for use of CBT for individuals with SMI is expanding and also includes group based interventions (Granholm, et al., 2005) and there is moderate meta-analytic support for the use of CBT for psychotic symptoms (Wykes et al., 2008). There is a high rate of substance use among individuals with SMI and individuals with co-occurring disorders should be offered substance abuse treatment tailored for SMI related impairments (Dixon et al., 2010). For these Veterans skills based, psychoeducation, and coping skills components of the Behavioral Treatment for Substance Abuse in Schizophrenia (Bellack et al., 2006) are provided. Finally, while the evidence base for Illness Management and Recovery (IMR) interventions is preliminary this psychoeducation and skills based group is well grounded in evidence based principles (Hasson Ohayon, 2007; Levitt et al., 2009). The importance of the recovery focus also warrants a brief comment. Recovery based services are not an evidence based practice per se but rather represent a paradigm shift in mental health care. Recovery has been defined by SAMHSA to include: hope, self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, and responsibility. As such, recovery is the context within which the above mentioned interventions are delivered and informs the manner in which, for example, treatment choices are presented and the way cases are conceptualized.

Supervisors' Training and Experience

Dr. Mary Gardner earned her Ph.D in Clinical Psychology from the University of Maryland, College Park, focusing on stress and coping as well as serious mental illness. She completed her internship through the MIRECC at the Perry Point VA Medical Center, unit 364A. In this setting she received training in diagnosis and treatment of serious mental illness, including token economy and social skills training. She participated in MIRECC-related research as well. Dr. Lambert accepted the position of unit psychologist upon completion of her internship, and remained in this position for the next 6 years. She then moved on to coordinate the Health Improvement Program at both the Baltimore and Perry Point sites for 2 years. In 2010 she was asked to lead the development of what later became known as the Perry Point Recovery Center. In this capacity she provides clinical services as well as administrative oversight to both the Recovery Center as well as the Perry Point PRRC.

Inpatient Treatment for Serious Mental Illness

Patient Population

The Veterans Affairs Maryland Health Care System, VAMHCS, mission is to "honor Americas Veterans as heroes by providing the highest quality health care." In service of this mission the Mental Health Clinical Center provides a continuum of care for Veterans and eligible family members, with a range of physical, mental health, and psychosocial needs. In this continuum of care 364A serves to provide sustained inpatient psychiatric care for Veterans that no longer have acute care needs. Sustained care provides a safe environment, for Veterans, until they are able to resume personally identified goals and roles in the community.

The treatment milieu utilizes the principles of Psychosocial Rehabilitation and Recovery to guide services provided to the Veterans receiving care. SAMHSA (2013) defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The guiding principles of recovery are strengths based approach that includes, instillation of hope, person-driven care, and holistic treatment that utilizes the natural and community supports available to assist Veterans in achieving self-identified goals.

The treatment milieu on 364A is designed to promote safety and recovery from mental health symptoms. The Veteran population includes men and women between the ages of twenty to eighty with a diversity of care needs, including mental health, physical care needs, and multiple psychosocial stressors. Diagnostically, Veterans present with all mental health symptoms, primarily Serious Mental Illness (SMI). This is a locked inpatient unit which means that Veterans are escorted to all off unit appointments and activities by a staff member. Daily activities are structured to encourage opportunities for physical exercise, hygiene, psychoeducation, therapy (individual and group), socialization, and medication management to teach skills that will promote future success when re-integrated into the community. The Veterans are able to attend Kinesiotherapy, Horticultural Therapy, Occupational Therapy, and Recreational Therapy activities. A multidisciplinary treatment team approach is used which includes active involvement by the Veteran to build on strengths. The length of stay varies based on Veteran need and is generally short-term.

The role of the Psychologist on the unit includes the provision of individual therapy, group therapy, patient education, staff education, family meetings, treatment team meetings and treatment planning, as well as psychological assessment. Due to the changing nature of the unit and Veterans receiving care the Psychologist must be flexible in creating treatment to meet the needs of the Veterans.

The intern will be fully integrated into the treatment milieu and the provision of services to the Veterans. They will learn the principles of psychosocial rehabilitation and practice those within the treatment milieu. They will provide individual and group therapy, complete psychological assessments and reports, and participate in treatment team meetings. Therapy approaches used with the Veterans are short-term evidence based interventions which have proven effective for the Veterans being served. These interventions may include, Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Seeking Safety, Illness Management and Recovery, Social Skills Training and Wellness Recovery Action Plans. The intern will have the opportunity to participate in program development as we continue to transform the unit milieu to a recovery focus. The intern and supervising psychologist will work collaboratively to meet the self-identified goals of the intern during the rotation. The methods which may be used in supervision include audiotape, co-therapy, observation, case discussion, and review of completed assessments and reports.

Supporting Literature

A recovery based model of treatment for those with a Serious Mental Illness diagnosis includes a combination of psychotropic medications and evidence based interventions designed to assist client's in learning symptom management skills, community living skills, and to identify meaningful community based roles they want to engage in. In addition, care needs to be provided with respect for patients preferences in intervention choice (LeVine, 2012). The first-line treatment for Schizophrenia is neuroleptic medication, although a majority of patients also benefit from the inclusion of psychosocial interventions (Lehman et al., 2003). These interventions include therapy, case management, and family psychoeducation (Lehman, et al. 2004). The treatment approach utilized on 364A is primarily Cognitive Behavioral Therapy. Cognitive Behavioral Therapy (CBT) is considered a short-term intervention designed to address mental health symptoms, reduce distress, and promote healthy behavioral responses in the here and now. CBT has demonstrated effectiveness in the treatment of Mood Disorders (Major Depressive Disorder and Bipolar Disorder); Anxiety Disorders (Panic Disorder, OCD, Specific Phobia, PTSD, GAD); Psychotic Disorders (Schizophrenia); and Substance Use Disorders, across age ranges (Leichsenring et. al., 2006). Cognitive Behavioral Therapy has demonstrated the "strongest evidence base" in the treatment of Schizophrenia (Dickerson & Lehman, 2006). In addition to CBT, Acceptance and Commitment Therapy is often utilized with the Veterans receiving care on 364A. ACT does not work on reducing symptoms, but instead focuses on how Veterans respond to symptoms that will allow for increased values-driven behavior (Bloy et al., 2011).

Supervisor's Training and Experience

This rotation is supervised by Dr. Julie Rife-Freese. Dr. Rife-Freese completed her Psy.D. at Argosy University, Washington, DC Campus and her internship training at the Coatesville VAMC, with a focus on providing services to Veterans with an SMI diagnosis. Upon completion of her internship training she continued to work with Veterans diagnosed with a SMI on an inpatient psychiatric unit at the Coatesville VAMC. This role included working toward transforming the unit milieu to a recovery orientation through the implementation of psychosocial rehabilitation principles. Dr. Rife-Freese was a member of the Internship Training Committee at the Coatesville VAMC for 4-years and supervised interns in both inpatient and outpatient settings. Dr. Rife-Freese is a full time psychologist on the inpatient stabilization unit (364A).

Mental Health Clinic

Patient Population

The mental health clinic serves approximately 4,000 Veterans in a given year, the majority of whom receive medication management. The average age of Veterans treated is in the early 40's. Veterans receive treatment for a variety of mental health conditions including major depression, anxiety disorders (i.e., PTSD), interpersonal relationship difficulties, bipolar disorder and dual diagnosis. A portion of these Veterans may also present with characterological issues.

Assessment, Treatment and Supervision

Training in this rotation will focus on competency as a generalist in an outpatient practice. Core skills will include assessment utilizing structured diagnostic interviews, bio-data, and objective psychological tests, individual psychotherapy using cognitive behavioral and acceptance and commitment therapy formulations, as well as group psychoeducation. Interns will also conduct at least one intake per week in the Mental Health Assessment and Referral Clinic (MHARC), allowing the opportunity to integrate data from an unstructured interview, chart review, and psychometric assessment to assist in case formulation for treatment and consultation to other mental health disciplines. In addition, the intern will complete at least two comprehensive integrated psychological assessments. Primary psychological instruments used will include brief structured interviews (such as the SCID, MINI, and CAPS) and objective psychometric measures (the PAI, MMPI-2, and MCMI-III). There is also the opportunity to obtain experience using symptom validity measures. Assessment referral questions typically address differential diagnosis for treatment planning.

The intern will carry a clinical caseload of 5-7 Veterans for individual psychotherapy. Ideally this will include following several cases from intake to resolution, including assessment, case formulation and a course of time-limited evidence-based psychotherapy. Psychotherapy training will emphasize evidence-based cognitive and behavioral techniques that have broad application across a number of diagnoses, including depression, anxiety, and emotion dysregulation. Treatment modalities include cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and Skills Training Affective and Interpersonal Regulation (STAIR). Interns interested in obtaining more experience with Veterans with PTSD will have the opportunity to provide individual assessment and therapy to Veterans with symptoms of PTSD, including evidence-based trauma therapies, such as Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Exposure Relaxation and Re-scripting Treatment (ERRT) for nightmares. Interns will also be involved in co-leading or leading at least two psychotherapy or psychoeducation groups through the Perry Point campus-wide Recovery Center (see description below).

As with other facilities within the VA, there has been a shift in how psychotherapy is delivered within the Perry Point Mental Health Clinic. There is greater emphasis on providing time-limited evidence based psychotherapies as opposed to long term supportive psychotherapy. This shift has required some ongoing education efforts to staff and Veterans alike. Thus the intern would have opportunity to assist in these education efforts as needs arise. This might include providing in-services to staff about a specific EBP or assisting in the development and conducting of an "introduction to psychotherapy" education group for Veterans.

Interns will have two individual, hour-long supervision sessions per week to discuss assessment cases, case conceptualizations, documentation, and individual psychotherapy cases. Additionally, interns will have the opportunity to discuss treatment modalities and to ask questions about professional development during supervision. Supervisors will also provide "on the spot" feedback during groups that the intern co-leads with the supervisor. The intern is always welcome to pop in with questions and/or concerns between supervision sessions. The general approach to supervision is collaborative, with the goal of supervision to ensure that the intern is getting the training experience that he/she desires.

Supporting Literature

Cognitive-Behavioral Therapy (CBT) is a time-limited, evidence-based intervention for depression, insomnia, and anxiety disorders, including social anxiety, generalized anxiety disorder, and panic disorder (Butler et al., 2006; Chambless et al., 2001; Gloaguen et al., 1998; Moran et al., 2006). Interns will have an oppoturnity to co-lead a group based on the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2010), a CBT treatment model that approaches emotional disorders from a shared phenomenology.

Acceptance and Commitment Therapy (ACT) is a third-wave therapy designed to help people increase their psychological flexibility and change their relationship with unpleasant experiences in order to move closer to their values (Hayes et al., 1999). ACT combines acceptance, cognitive defusion, and mindfulness principles to help people to change their relationship with thoughts. ACT has been shown to be an effective treatment for depression, psychosis, substance use disorders, and chronic pain (Hayes et al., 2004).

With regard to EBPs for PTSD, exposure therapy (Foa et al., 1991; Keane et al., 1989) has been consistently demonstrated as an effective treatment for addressing specific traumatic memories; this approach has been endorsed by the Division 12 Task Force as an efficacious treatment for PTSD. Additionally, Cognitive Processing Therapy (CPT) has also been shown to be an efficacious treatment for Veterans with PTSD (Monson et al., 2006). Exposure Relaxation and Re-scripting Treatment (ERRT) has been shown to be effective in treating nightmares related to PTSD (Davis, 2009). The use of anxiety

management training has been empirically supported in the PTSD and other anxiety research literature (Foa et al., 2000).

Supervisor's Training and Experience

Supervision for group based and individual interventions and assessment will be provided by Dr. Christine Calmes, Dr. Michael Poet, and Dr. Ashley Greer.

Dr. Calmes received her doctorate from the State University of New York-Buffalo and completed her pre-doctoral internship at the University of Maryland/VA Maryland Healthcare System (VAMHCS) consortium through the VA serious mental illness track. She completed one year of a post-doctoral fellowship through the MIRECC in which her research and clinic interests focused on family involvement in the mental health care of Veterans with serious mental illness and internalized stigma associated with mental illness. Given her training, Dr. Calmes has a special interest in treating Veterans with PTSD and comorbid serious mental illness. Dr. Calmes is currently providing trauma-based therapy to Veterans on an outpatient basis through the Mental Health Clinic at the Perry Point VA. She is a VA certified provider of Cognitive Processing Therapy (CPT), Motivational Interviewing (MI) and Cognitive Behavioral Therapy for Insomnia (CBT-I).

Dr. Poet earned his doctorate from La Salle University in Philadelphia, PA. He completed his pre-doctoral internship at St. Elizabeth's Hospital in Washington, DC. He is a staff Psychologist in the Perry Point Outpatient Mental Health Clinic, where he conducts psychodiagnostic evaluations and provides evidence-based individual and group-based psychotherapy with Veterans who present for a wide range of Mental Health issues. Dr. Poet practices from a Cognitive-Behavioral orientation with a focus on Acceptance and Commitment Therapy (ACT). He is a VA certified provider of Acceptance and Commitment Therapy (ACT) for Depression, Motivational Interviewing (MI) for Behavior Change, Interpersonal Psychotherapy (IPT) for Depression, and Prolonged Exposure (PE) for PTSD.

Dr. Greer completed his Ph.D. at Fielding University and his pre-doctoral internship at the Devereux Foundation in Pennsylvania. He is a staff psychologist in the Perry Point Outpatient Mental Health Clinic and provides both individual and group therapy from an existential-humanistic perspective. He also utilizes Cognitive Processing Therapy (CPT), Motivational Interviewing (MI), and Exposure Relaxation and Re-scripting Treatment (ERRT) in individual therapy and leads weekly groups in Motivational Enhancement Therapy for Substance Use disorders and Suboxone treatment for Opiate Use Disorders.

Primary Care-Mental Health Integration (PCMHI) Rotation – Perry Point

Patient Population

The primary care clinic in Perry Point is a small, rural clinic, with approximately 6 primary care providers serving 4,800 Veterans. The average age of Veterans in this clinic is 60 and the majority (80%) are male. Veterans receive care within Patient Aligned Care Teams (PACT), which are patient-centered medical homes that are structured to provide coordinated, accessible, and patient-centered healthcare. As all PCMHI providers do, interns will function as integrated members of the PACT by providing consultation to primary care providers and the PACT teams, having availability to see patients on the day of their primary care visit, and attending and contributing to PACT team meetings.

Assessments, Treatments, & Supervision

Interns will have the opportunity to provide brief (30 min.), targeted behavioral health assessments for Veterans who are referred by their primary care team. The purpose of assessments in PCMHI is to clarify the presenting problem and triage the Veteran to the appropriate treatment setting. Veterans who are appropriate for treatment in PCMHI include those with common, uncomplicated presenting problems, such as depression, anxiety, tobacco use, obesity, adjustment issues, adherence problems, enhancing

health behaviors, uncomplicated grief, and chronic pain. Most patients presenting to PCMHI can be treated/managed within this setting. Interns will learn to tailor assessments to the particular Veteran and his/her presenting problem. Depending on patient presentation and the nature of the referral, assessments may include administration of brief measures, such as the Patient Health Questionnaire-9 (PHQ-9), Posttraumatic Stress Disorder Checklist (PCL), Generalized Anxiety Disorder-7 item scale (GAD-7), Montreal Cognitive Assessment (MoCA). Interns may also have the opportunity to complete pre-transplant evaluations on this rotation.

Interns will have availability to see both scheduled patients and walk-in patients (warm hand offs) from primary care providers. Patients who are typically referred to PCMHI include those with depression, substance use disorder, PTSD, anxiety, tobacco use disorders, obesity, diabetes, chronic pain, and insomnia. Treatment in the primary care setting is brief (up to 6, 30 minute sessions) and evidence-based. Interns will utilize a wide variety of brief interventions, including behavioral activation, motivational interviewing, relaxation training, and brief CBT. Interns may have the opportunity to provide individual as well as group treatments. Group opportunities may include diabetes management group, weight management group (MOVE), pain school, depression group, and mindfulness-based stress reduction for medical conditions.

Supporting Literature

Integrated Primary Care: Integrated care can increase access to mental health care, reduce the burden on specialty mental health clinics, and modify willingness of primary care providers to address mental health concerns (Brawer, Martielli, Pye, Manwaring, & Tierney, 2010; Felker et al., 2004). It may also serve to reduce the stigma associated with mental health treatment, as a higher number of patients engage in treatment when it is integrated into primary care versus when it is delivered in specialty mental health (Bartels, 2004). Primary care providers have positive perceptions of integrated care, with the majority reporting that integrated care leads to better communication between primary care providers and mental health providers, less stigma, better coordination of care, and better management of depression, anxiety, and alcohol problems (Gallo et al, 2004).

Brief Interventions: Interventions utilized in this setting are brief and evidence-based. When designing interventions, PCMHI clinicians take into consideration the best available evidence along with patient characteristics and clinical expertise to develop a treatment plan that is grounded in research and also tailored to each individual Veteran's specific needs. Given the breadth of patients seen in primary care, only a review of some of the most common interventions will be discussed. Examples of common interventions include behavioral activation, brief CBT, and motivational interviewing.

Brief (4 session) primary-care based behavioral activation has been shown to reduce symptoms of both anxiety and depression in Veterans (Gros & Haren, 2011). Brief CBT has been shown to be effective in the treatment of depression and anxiety (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Nieuwsma, 2012). A recent Cochrane review found that CBT for pain has positive effects on disability, mood, and pain catastrophizing (Williams & Eccleston, 2012). Brief behavioral intervention has been shown to be effective in treating insomnia (Buysse, 2011). Finally, brief motivational interviewing has been shown to reduce risky drinking behavior (Brown et al., 2010).

Supervisor's Training & Experience

Dr. Schneider earned her doctorate in clinical psychology from La Salle University with a health psychology concentration. She focused on chronic pain, coping, and acceptance of pain during her graduate training. She completed her internship at the Miami VA Medical Center, with training in the psychological assessment and treatment of various geriatric and medical patient populations, including cancer, medical inpatient consultation and liaison, hospice/palliative care, chronic pain, and transplant. She then completed a one-year postdoctoral fellowship at Salem VA Medical Center, with a focus on

primary care-mental health integration and behavioral medicine (chronic pain, diabetes, transplant, and bariatric surgery candidates). Dr. Schneider's career experiences have focused on chronic disease management, coping with chronic illness, health behavior changes, and chronic pain management. Outside of supervision with Dr. Schneider, interns will have a variety of learning opportunities that are relevant to the primary care setting and appropriate to the level of experience and specific interests of the intern. For example, interns may shadow PACT team members (nurses, primary care providers, dieticians), present health psychology topics to primary care providers at meetings, and become familiar with relevant literature on collaborative healthcare.

Residential Treatment Rotation Description

Patient Population

The patient population in residential treatment at the Perry Point VA includes a wide age range, from returning Iraq and Afghanistan veterans to Vietnam era veterans. Most patients are male but female veterans are represented as well. Patients vary diagnostically and may present with major depression disorder, bipolar disorder, anxiety disorders including PTSD, psychotic disorders, substance use disorders, and personality disorders and/or issues. Many of the patients grapple with homelessness, unemployment and other significant psychosocial stressors. In terms of severity, patients possess a level of functioning that is non-acute, though occasionally patients' symptomology increases while in residential treatment. Often patients struggle with outpatient psychotherapy engagement and a significant treatment goal is to help create a smooth step-down to a lower level of care in preparation for the completion of residential treatment.

Assessments, Treatments, and Supervision

Interns will have the opportunity to participate in both assessment and treatment interventions. Assessments pertain to the referral question posed and often have to do with diagnostic clarification, including understanding personality structure. Brief cognitive screens are also performed with some regularity. Resulting findings and recommendations are used to help staff guide the course of treatment for patients. Interns will also be able to participate in Residential Screening Interviews, typically for one half day a week, where they serve as a panel member that helps determine if patients presenting in-person or via phone are appropriate candidates for a residential level of care and which program best suits their needs. Interns may have the opportunity to follow patients through several levels of care in their treatment, such as detoxification, acute psychiatry, sustained psychiatry, residential, aftercare, and outpatient treatment. Individual psychotherapy, process group, and psychoeducation group training experiences are also an integral part of the internship rotation; see below for program specific details. Exposure to families and couples interventions may also be available.

Each intern will receive two hours of individual supervision a week, which can be completed with one primary supervisor or two supervisors, depending on intern preference. Video and auto recordings of sessions may be reviewed, collaboratively. Flexibility exists with the number of days available for training in a residential treatment program. A major rotation is typically 3 to 4 days and a minor rotation is 1 day a week. An option exists to intern at 1 residential program the majority of the week and also spend 1 day at another of the residential programs.

Clinical Settings

Domiciliary Residential Rehabilitation and Treatment Program (DRRTP)
The DRRTP is a 30 bed residential treatment program providing services to homeless Veterans who seek housing and employment in the community. The DRRTP utilizes an employment-focused model with a strong therapeutic community, based on both peer and staff support. The ultimate goal is for Veterans to

re-integrate into independent living in the community. The DRRTP residence is currently only partially open with 30 beds, with 17 additional beds to be available in the future; it is open to male and female Veterans. Veteran residents stay 4 to 6 months, on average. The DRRTP is focused on helping each Veteran meet his/her highest level of functioning. This often means gainful employment for most Veterans, though some pursue school, volunteering, or other means to feeling useful and productive. DRRTP staff includes individuals from a wide array of disciplines including psychology, social work, psychiatry, medical, occupational therapy, nursing, and recreational therapy. Together, these staff members form the treatment team who assist the Veterans in reaching their treatment goals.

Programming includes group and individual therapy, case management, job and housing searches, as well as participation in monthly treatment teams to review treatment goals and progress through the program. Current group therapy is focused on treating the typical presenting concerns of DRRTP residents, including both psychoeducational and process-oriented groups. Some of the current groups include Anger Management, Relating to Others (incorporating newly learned skills to past and current relationships), Stress Reduction (integrating Mindfulness-based and relaxation techniques/training), Problem Solving, Leisure Skills and Community Integration, Relapse Prevention, Spirituality, and Wellness (linking physical health to bio-psycho-social factors). Individual therapy is typically brief and solution-focused for presenting concerns such as anger management, relapse prevention, depression, anxiety, and grief. Assessments may also be a part of individual therapy, as clinically indicated.

Interns can expect to lead therapy groups, either existing groups or creating new groups, based on the needs of the resident population. Interns will also be able to carry a small caseload of individual therapy/assessment patients, provide case management, and assist with discharge planning. Interns are encouraged to work as a member of the DRRTP treatment team, including recommending and creating additional programming which may benefit our Veteran residents.

Psychosocial Residential Rehabilitation and Treatment Program (PRRTP)

The Perry Point PRRTP is a 71-bed voluntary residential program with a 90 – 100 day length of stay that offers Veterans with psychiatric disorders treatment focused on improved symptom management and community reintegration. The PRRTP provides a 24-hour therapeutic setting utilizing a milieu of peer and professional support with a strong emphasis on psychosocial rehabilitation and recovery services that instill personal responsibility to achieve optimal levels of independence upon discharge to independent or supportive community living.

The PRRTP provides a recovery oriented milieu as the context for participation in clinical treatment. The recovery partner and the treatment team with the Veteran as the driving force of the planning process determine the best interventions that will assist the Veteran in the recovery process. The PRRTP provides evidenced-based treatment to include early recovery interventions/groups, substance abuse groups, discharge planning groups, Veteran-led community government groups, Peer Support led groups and social skills training groups. Veterans must participate in a minimum of four hours of group therapy per day. Veterans can also be referred to the following programs while residing within the PRRTP based on needs:

- Substance Abuse Intensive Outpatient Treatment (IOP): for Veterans who identify active substance abuse as having a direct impact on their inability to maintain sobriety. This is a three (3) week program with aftercare following completion of the core program.
- Psychosocial Rehabilitation Recovery Center (PRRC): The PRRC is a recovery-based day program for seriously mentally ill Veterans. The PRRC meets five (5) days per week and focuses on community re-entry through group education and experiential community activities.
- Recovery Center: Provides evidenced=based psycho-educational groups in topics such as Acceptance and Commitment Therapy (ACT), Depression, Mindfulness, Cognitive Behavioral Therapy (CBT) and Meditation to name a few.

- Vocational Services: can be an option for Veterans who have a desire to get back into the work force.

Discharge planning begins at the time of admission to the PRRTP. Social Workers, recovery partners and other team members assist the Veteran in defining a community reintegration goal and help the Veteran develop a step-by-step plan to meet that goal. The Veteran's return to the community may take many forms based on his/her situation. Some Veterans may choose a supervised community residence or an unofficial boarding home with VA Case Management services. Other Veterans participate in the VAMHCS Transitional Work Experience Residential Program or seek housing through the CHEP program on-station. Many Veterans return home to family or establish fully independent community living. In all cases, Veterans are expected to continue their treatment. Veterans are set up with follow-up appointments on an outpatient basis, either within the VAMHCS or at another VA facility closer to their home. Veteran participants in the PRRTP are taught that recovery is an on-going journey that requires commitment and hard work.

Substance Abuse Residential Rehabilitation and Treatment Program (SARRTP)

The SARRTP is a 62-bed residential treatment program designed primarily to address substance use disorders. Issues with homelessness and unemployment are also common targets of treatment. Currently, the building is under construction; patient census is approximately 30. Staff offices, group rooms, and patient bedrooms reside in the renovated portion of the building. In addition to residents in the SARRTP, patients from the PRRTP and, occasionally from the community, join together during the daytime programming, referred to as the Intensive Outpatient Program (IOP). Approximately 10 patients at a time participate in the IOP. Daytime programming for SARRTP residents and IOP patients are synonymous and runs for 21 days. Length of stay in the SARRTP varies from 21 to 100 days. Aftercare groups also meet and some patients are followed in an outpatient basis in this way.

The content of the daytime programming takes the form of process and psychoeducational groups, drawing from four primary treatment modalities. Treatment approaches include 12-Step Facilitation, Motivational Enhancement Therapy, Cognitive Behavior Therapy, and Mindfulness practice. Additionally, each week of programming centers around a particular theme, which are: Week 1: Gaining Clarity and Developing Compassion (Acceptance), Week 2: Change and, Week 3: Connections. Interns may select a particular treatment modality to focus on during the rotation or select experiences across approaches.

As an example of the day to day activities while in a 3 day a week rotation, the intern sees 4 patients for individual psychotherapy and light case management. If rotating Monday-Wednesday-Friday, the intern participates in all three process therapy groups offered during the week. The intern also partakes in 2-3 psychoeducational programs co-led by a psychologist or with staff from other disciplines. In addition to these activities, interns also develop and enhance their skills at operating on a multidisciplinary team and being a member of the milieu. The treatment team meets every day for morning report and to address patient issues that have arisen that would benefit from staffing. The treatment team and patients also divides up into four "squads" to help individualize care. Interns will participate in writing treatment plans that are developing during squad collaboration.

Supporting Literature

Motivational Enhancement Therapy, 12-Step Facilitation, and Cognitive Behavioral Therapy have all been found effective for the treatment of substance abuse disorders (NIAAA Project MATCH, 1996). Mindfulness based approaches to addiction also garnish empirical support, particularly for relapse prevention (Marlatt & Donovan, 2005). Problem-solving therapy helps to teach an individual to manage the negative effects of stressful life events (Nezu, Nezu, & D'Zurilla, 2013). Anger management for

substance abuse and mental health clients (SAMHSA, 2013) teaches clients to identify cues to anger and offers strategies for avoiding anger outbursts and their negative effects.

Supervisor's Training and Experience

Catherine Pilotte Mullins, Ph.D. Dr. Pilotte Mullins earned her doctorate in 2012 from Purdue University's Counseling Psychology program. She completed her pre-doctoral internship at the Syracuse VA Medical Center, completing rotations in Outpatient Mental Health, Outpatient Substance Abuse treatment, Health Psychology, and Psychosocial Rehabilitation and Recovery Center. As an intern she also received additional training in inpatient and outpatient assessment, Prolonged Exposure, and Cognitive Processing Therapy. Dr. Pilotte Mullins has additional clinical experience working in both residential and outpatient substance abuse settings, working with dually-diagnosed adolescents in a residential treatment center, and with college students with career-related concerns. She integrates client-centered, cognitive behavioral, and motivational interviewing approaches into her clinical work.

Frederick Martin, Psy.D. Dr. Martin earned his doctorate in 1995 from the California School of Professional Psychology in Los Angeles. He completed his pre-doctoral internship at the Perry Point VA Medical Center in Maryland with rotations in Inpatient, Geropsychology, and Community Mental Health. Additional clinical experience includes over twenty years of providing mental health services in both inpatient and outpatient settings in the VA in Baltimore and Los Angeles. He has been a national trainer for Social Skills Training (SST) for the past seven years. He was a Local Recovery Coordinator for the Los Angeles VA Healthcare System and has been a coordinator of a Substance Use Disorder treatment clinic at the Los Angeles VA. He is currently the Coordinator of the Mental Health Psychosocial Residential Treatment Program (MHPRRTP) located in Building 24 at Perry Point. Dr. Martin integrates cognitive-behavioral and psychodynamic approaches in providing mental health services.

Matthew Lebovits, Ph.D. Dr. Lebovits earned his doctorate in 2012 from the California School of Professional Psychology in San Diego. He completed his pre-doctoral internship at the Brooklyn VA Medical Center in New York with rotations in Substance Abuse, Chronic Pain, and Hepatitis C. Additional clinical experience consists of active-duty military, residential, and outpatient settings including the Naval Medical Center in San Diego and Children's Hospital. He currently serves as a Staff Psychologist in the PRRTP where he conducts individual and group psychotherapy with Veterans struggling with substance use and a range of other mental health disorders. Dr. Lebovits integrates cognitive-behavioral, psychodynamic, motivational enhancement, and mindfulness-based approaches in his work.

Perry Point Supplemental Training Opportunities

<u>The Recovery Center</u>

The Mental Health Recovery Center is a recent VAMHCS clinical initiative implemented to increase access to, efficiency in, and satisfaction with mental health services at the Perry Point campus. In brief, the Recovery Center is designed to be a "one-stop shop" for multidisciplinary mental health psychoeducational and therapeutic services. Veterans from across the Perry Point campus (both inpatient and residential settings) and surrounding community are able to select from a "course catalog" of treatment groups and classes relevant to their personal recovery goals. Groups and classes include evidence based mental health interventions, skills based, wellness/recovery oriented and supportive therapy groups addressing a wide range of psychosocial issues that Veterans are faced with. These include for example, mood, anxiety, trauma, chronic pain, substance use, co-occurring medical conditions, TBI and other skills related (e.g., budgeting) and relationship issues. In addition to offering a comprehensive array of services, the Recovery Center also strives to make accommodations so that no Veteran is deemed "inappropriate" for services in order to maximize access to services. The rationale for this method of service delivery is to enhance the VAMHCS' ability to provide a continuum of care designed to be more accessible and individualized for Veterans seeking mental health services.

As a point of clarification, the Recovery Center is not designed to replace specialized treatment programs such as, for example, substance use disorders and trauma but rather is an opportunity for Veterans to supplement this treatment with additional groups and classes. This arrangement enhances efficiency by removing the redundancy of offering multiple groups targeting the same problem (e.g., anger management) across programs and units. Also the Recovery Center is distinct from the PRRC in that it serves all Veterans regardless of diagnosis or functional impairment, whereas the PRRC is tasked with serving Veterans with severe mental illness and resulting functional impairment. However, Veterans enrolled in PRRC are not excluded from participating in Recovery Center groups as well.

Interns who select rotations at the Perry Point campus will have the opportunity, with input from their primary supervisor, to supplement their training with Recovery Center clinical activities. These opportunities include co-facilitating groups such as Seeking Safety, Sleep Hygiene, CBT for depression and anxiety, mindfulness meditation, Anger Management, and Chronic Illness Support Group. For particularly industrious interns there may also be opportunities to develop and implement (with supervisor support) a specific time limited group during their rotation.

For the interested intern there are also program evaluation and program development opportunities within the Recovery Center as well as in other Perry Point programs (e.g., PRRC). These include, for example, measuring Veteran satisfaction with services, needs assessment, evaluating outcomes, assessing program efficiency and related performance improvement activities. These are small scale and time limited clinically focused projects but are an opportunity to get ones' hands dirty with real world data. Interns would have the opportunity to participate in several ongoing workgroups associated with the Recovery Center including a program evaluation and needs assessment workgroup or a clinical programming workgroup.

Clinical Rotations – Loch Raven CBOC

Hospice/Palliative Care Rotation

Patient Population

The patient population of the hospice program spans a wide range of diagnostic categories, level of functioning, and severity of illness. The age range of Veterans on the hospice unit is generally between early 50's to late 80's. Many of the Veterans admitted suffer from chronic liver disease, cardiovascular disease and/or some form of cancer, generally lung or pancreatic with metastases. The older Veterans may also have an underlying form of dementia or related cognitive disorder. Interns working on the hospice rotation will work with a wide range of mental health disorders, including a history of Substance Use Disorder, Depression, Anxiety, and Post Traumatic Stress Disorder. Also, interns will have the opportunity to work with patients' families and staff members to deliver interventions for caregiver support and burnout.

Assessments, Treatment and Supervision

This major rotation is designed to provide interns the opportunity to work predominantly with patients on a 12 bed inpatient hospice unit and to interact collaboratively with an interdisciplinary team. Interns will evaluate patients upon admission to the hospice unit for underlying psychopathology (i.e. depression, anxiety, adjustment disorders, suicidal ideation vs. desire for dying process to be over, PTSD, personality disorders, chronic mental illness, underlying delirium). From those evaluations, a caseload will be assigned for the intern to follow. Depending on the schedule, interns will also be expected to attend weekly hospice rounds and interdisciplinary team/family meetings. The interns will have weekly supervision and will develop knowledge and skills for working with normative and non-normative grief and bereavement. In addition, assessment of specific psychosocial and mental health issues common in patients with chronic, life limiting or terminal illness and their families will also be addressed. Interns will also develop the ability to modify practice to accommodate end of life context with regard to self-disclosure, boundaries, structure, ability to community effectively with medical and non-medical

professionals without psychological jargon, etc. The turnover rate on the hospice unit can be rather fast with patients staying on the unit anywhere from months to days. If necessary, caseload can be expanded with residents in the rehabilitation or nursing home units. In addition to initial evaluations, interns will have the opportunity to conduct evaluations associated with decisional capacity and factors contributing to/complicating decisions.

In addition, the intern will be responsible for leading a weekly caregiver support group which is offered to family members of current and past patients of the hospice unit as well as other family members of the CLC patients who have been diagnosed with a terminal illness. The intern will also have the opportunity to participate in a monthly support group offered to hospice staff members.

Supporting Literature

Journal of Palliative Medicine, Psychooncology, Journal of Pain and Symptom Management
APA online end-of-life training modules
Stanford End-of-Life Care curriculum (http://www.growthhouse.org/stanford/modules.html)
National Cancer Institute Education in Palliative and End-of-Life Care for Oncology (EPEC-O)
End of Life/Palliative Education Resource Center (EPERC)
End of Life Nursing Education Consortium (ELNEC)
Duke Institute on Care at the End of Life (http://www.iceol.duke.edu/)
Fast Article Critical Summaries for Clinicians in Palliative Care (PC-FACS)

Supervisor's Training and Experience

Steven Butz, Psy.D. is the Clinical Geropsychologist and Neuropsychologist for the Loch Raven Community Living and Rehabilitation Center. He obtained his doctorate degree in clinical psychology from Loyola University of Maryland where he is also an affiliate faculty member. He completed a post-doctoral fellowship in geropsychology through the VA Boston Healthcare System/Harvard Medical School. His clinical work has been conducted in both outpatient and inpatient settings with responsibilities that have included neuropsychological testing, decisional capacity evaluations, psychotherapy, and behavioral management for residents in a variety of outpatient and inpatient settings, including independent living, assisted living, nursing home, rehabilitation and hospice units.

University of Maryland Baltimore Rotations

University of Maryland Baltimore Adult Psychology Track

Overview

The University of Maryland Baltimore Adult Psychology Track is located within the Department of Psychiatry at the University of Maryland, School of Medicine. The Department of Psychiatry has a long-standing commitment to the scientific study and treatment of serious mental illness and the recovery of individuals with SMI, and so provides a particularly rich clinical training and research environment for interns with these interests. Two clinical sites within the Department are part of the University of Maryland Adult Psychology Track: (1) The University of Maryland Medical Center (UMMC) Adult Outpatient Psychiatry Clinic and (2) the University of Maryland Community Fayette Adult Clinic. These clinics have a long history of serving the mental health needs of individuals in the public sector in the Baltimore metropolitan area and adhere to a Recovery Model that emphasizes validation, strength, hope, respect, and empowerment. Within this model, recovery is considered a process, not an end state or outcome. Services at both clinical sites are provided with an emphasis on evidence-based practice and client involvement in the treatment process, including collaboration on the selection of treatment targets and intervention strategies.

The population served at both clinics is diverse with regard to both diagnosis and illness severity. The location of these clinics in downtown Baltimore means that they serve an urban population that experiences significant

barriers to mental health care and recovery. Both clinics serve adults age 18 and over who present with a broad range of emotional and behavioral problems, including mood disorders, anxiety disorders and post-traumatic stress disorder, schizophrenia and other psychotic disorders, personality disorders and co-occurring psychiatric, medical, and substance use disorders. Referrals to these clinics come from a many sources, including the department's Psychiatric Assessment and Referral Center, Psychiatric Emergency Services, the Inpatient Psychiatry Unit at the University of Maryland Medical Center, clinics within the department's Child and Adolescent Psychiatry Division, programs within the University of Maryland Medical Center, and the surrounding community. Both clinics provide intake and diagnostic evaluation, individual and group therapy, medication evaluation and management, and case management services. In addition, both clinics adhere to a multidisciplinary team model that includes psychiatrists, psychiatric residents, social workers, and nurses along with the psychology intern. Importantly, both clinical sites work to incorporate empirically validated interventions as part of clinical service, and function within a mental health service delivery system that is adapting to the demands of an ever changing mental health care environment.

There are two Adult Psychology Track interns, and each has a year-long placement at one of these two clinics. Detailed descriptions are below. At both, the intern serves as an integral member of the clinic's multidisciplinary team and functions with increasing independence as the year progresses. Both interns gain supervised experience providing a range of services including intake and diagnostic evaluation, individual and group cognitive-behavioral and behavioral interventions, and psychological assessment. Interns can co-lead behaviorally oriented treatment groups on topics related to coping and symptom management, trauma, CBT for psychosis, dual disorder, social skills training, and health behavior change topics such as smoking cessation. Interns may be afforded the opportunity to develop group treatments that they hold interest or expertise in as well. Opportunities also exist for co-leading groups related to coping with grief and loss, empowerment, recovery, and acknowledging and healing self-stigma. As part of the treatment team, interns attend team meetings and present at case conferences. Interns at both sites are also involved in aspects of case management and care coordination for their clients in order to support their trust in treatment seeking, engagement and success in mental health treatment. Interns at both clinics maintain a caseload of approximately 20 individual therapy cases and co-lead one to two groups. They receive approximately two to three hours of individual supervision and one to two hours of group supervision per week from psychologists and, when applicable, other mental health professionals. It is highly valued that interns are well-supported in managing their resilience and development while working with a challenging trauma impacted population. Additional administrative supervision is also provided to ensure that interns function in accordance with clinic procedures. Overall, the opportunity to complete a year-long placement at these clinics allows the intern to function as the face of psychology, developing relationships with other psychologists within the larger treatment team, and to provide services with the context of a community mental health clinic for an extended period of time.

University of Maryland Medical Center (UMMC) Adult Outpatient Psychiatry Clinic (701 W. Pratt Street, 2nd Floor)

The Adult Outpatient Psychiatry Clinic provides comprehensive assessment, psychiatric diagnostic evaluation and a variety of treatment interventions for people with a wide range of mental health problems. Located on the western side of downtown Baltimore, Maryland the program serves a varied group of clients from the local community, including inner city poor neighborhoods, the Department's psychosocial rehabilitation program Harbor City Unlimited, and referrals from the University of Maryland Medical Center, such as the Shock Trauma Center and Woman's Health Center. Service recipients are between 18 and 65 years of age, the majority being diagnosed with affective and anxiety disorders. The staff is currently composed of psychologists, a social worker, third year psychiatry residents, a psychology intern and staff psychiatrists. The clinic has developed a trauma informed approach to care given that the majority of the clients have been subjected to childhood and/or adult trauma that influences their symptoms and response to treatment. Interns attend didactics on Fridays at 10 am and participate in clinic meetings on Fridays at Noon. They also attend the VA TRP didactics focused on advanced topics in PTSD assessment, intervention, and consultation (see page 8).

Treatment modalities in the clinic include individual psychotherapy, group therapy, and medication management.

The theoretical orientation(s) of clinic staff is diverse. Clinicians utilize and can provide supervision in the implementation and integration of various treatment modalities including motivational interviewing/enhancement, CBT, DBT, psychodynamic, interpersonal, supportive, and other empirically supported interventions.

The Psychology Intern is a full member of the treatment team, providing individual and group treatment as well as intake and psychological assessments. Clients present with a wide array of difficulties and diagnoses. Most common are moderate to severe mood and anxiety disorders and bipolar spectrum disorders. Substance abuse histories are not uncommon. Most clients report a developmental history of trauma that affects emotion regulation and their ability to function effectively in their environments and with others. A typical case load usually has 20-25 clients, who are most frequently low-income minority women with children living in urban settings, but not exclusively. Opportunities to do couples therapy and family sessions with other adult family members may be available. A strong relationship with the child clinic on the same floor has been fostered such that children of adult clients can be referred for treatment in-house and/or the family as a whole can be referred to treatment. On the treatment team, the Psychology Intern plays an important role in providing a psychological perspective of the development of psychopathology and of recovery and trauma-informed treatment, and is expected to actively participate in all aspects of treatment plan development and relevant clinic operations.

University of Maryland Community Fayette Adult Clinic (701 W. Pratt Street, 3rd Floor)

The Fayette Clinic specializes in the treatment of adults with serious and persistent mental illnesses , although its clientele is quite varied. Overall, most are between 18-65 years old, and approximately 25% are diagnosed with a schizophrenia spectrum disorder. Poverty and other social problems complicate the clinical picture for many clients, as well as a variety of somatic problems. As noted above, a number of services are available at the Fayette Clinic, and the intern involved in providing all of these services to individuals on his/her caseload.

The Psychology Intern is a full member of the Adult Team at the Fayette Clinic, carrying a caseload of approximately 20 clients who experience serious mental illness. The multidisciplinary team of psychiatrists, social workers, and clinical nurses works together to provide psychological and psychiatric care with a recovery-based philosophy. This is a very cohesive clinic where many staff members have worked for decades. The intern provides a significant amount of case management/care coordination services, which may be in concert with other services within the Division of Community Psychiatry, including the Continuous Care Team (described below), intensive case management services, the Child/Adolescent Team, and Harbor City, the affiliated psychosocial rehabilitation program located nearby. The intern also works with social workers on the team to identify appropriate resources in the community. The clinic has a strong dedication to dual diagnosis services, with a specialist in this area and several groups for clients at different stages of change in their addictions.

The Fayette Clinic runs alongside two specialty teams in the Division of Community Psychiatry: the Continuous Care Team (CCT) and the Program of Assertive Community Treatment (PACT). CCT is an intensive outpatient psychiatric treatment and case management service located in the same building as the Fayette Clinic. It is designed to assist individuals with serious and persistent mental illness in reducing psychiatric hospitalizations and improving community functioning, integration, and quality of life. CCT provides consistent outreach and coordination of care in all aspects of treatment. PACT is an interdisciplinary mobile outreach treatment team that is staffed by psychiatrists, nurses, social workers, counselors and an employment specialist. The PACT Team was initially a federally funded research project to determine the effectiveness of a PACT model with homeless mentally ill adults. Now (since August 1993), it is a freestanding treatment service in the Division of Community Psychiatry.

As mentioned above, psychology interns also work closely with staff and clients at Harbor City Unlimited (HCU), a psychiatric rehabilitation center run by the Division. HCU provides a range of psychiatric rehabilitation services to adults with SMI including residential rehabilitation, a day program, off-site supported living, and vocational rehabilitation. The day program provides access to and assistance with social, recreational, educational and personal adjustments into the community, and offers a clubhouse model organized into units responsible for

the daily operation of the program as well as structured rehabilitation classes. Interns often have individual clients who also attend HCU, as well as have the opportunity to do a minor rotation there.

Supervision

Clinical supervision is provided by several University of Maryland Faculty. The main Adult Track supervisors are as follows:

Laura Anderson, Ph.D. Dr. Anderson is a psychologist at the Outpatient Psychiatry Clinic (2nd floor). She conducts group supervision, postgraduate training, and individual/group psychotherapy. Her interests include treatment of complex trauma, dialectical behavior therapy, psychodynamic conceptualization, mindfulness, therapeutic alliance, supervision and training. Dr. Anderson provides weekly trainings and offers consultation for interns and staff on the Outpatient Psychiatry Clinic (2nd floor).

Melanie Bennett, Ph.D. Dr. Bennett is an Associate Professor of Psychiatry at the University of Maryland, School of Medicine, and a researcher at the Center for the Behavioral Treatment of Schizophrenia. Her work has focused on the assessment and treatment of substance use disorders in individuals with serious mental illness, with a particular emphasis on tailoring empirically supported interventions and motivational enhancement approaches for this group of substance abusers. Dr. Bennett supervises assessments and half of the therapy caseload for the Community Fayette Adult Clinic (3rd floor).

Richard Goldberg, Ph.D. Dr. Goldberg is a Professor of Psychiatry at the University of Maryland, School of Medicine and the Director of the VA Capitol Health Care Network (VISN 5) Mental Illness Research, Education and Clinical Center. His work focuses on the development, evaluation and implementation of recovery oriented treatments and services for individuals with serious mental illness. Dr. Goldberg provides supervision in group psychotherapy for the intern working at the Community Fayette Adult Clinic (3rd floor).

Miranda Kofeldt, Ph.D. conducts individual and group psychotherapy as a psychologist at the University of Maryland Medical Center Adult Outpatient Psychiatry Clinic (2nd floor of 701 W. Pratt St), where she completed her internship. She provides clinical and assessment supervision of the intern in this clinic. Her clinical approach and interests focus on the Transtheorectical Model of Behavior Change, motivational interviewing and motivational enhancement techniques, trauma-informed approaches to treatment, and cognitive behavioral therapies.

Alicia Lucksted, Ph.D. is a clinical-community psychologist and research faculty at the UM Psychiatry Department Center for Mental Health Services Research, and the VISN-5 VA MIRECC. Her work focuses on consumer experiences of mental health services, interventions to reduce stigma and its consequences in clinical and peer settings, and the recovery paradigm. She supervises half of the individual therapy caseload for the Community Fayette Adult Clinic (3rd floor).

Administrative supervision is provided for each intern by a member of that clinic's administrative and clinical staff.

Assessment

Consistent with the overall Consortium assessment requirements, both UM SOM Adult Track interns will be supervised in the completion of 6 assessment batteries and comprehensive reports. Referrals often come from members of the clinic treatment team and involve in-depth diagnostic assessment of complex cases, personality assessment, and cognitive and intellectual functioning. Interns are expected to provide feedback and education regarding recommendations to clients and other clinicians on the treatment team. Assessments may also occur within the context of VA clinics or as part of a minor rotation at the VA.

Minor Rotations

UM SOM Adult Track interns can choose to participate in minor rotations/placements throughout the year and can tailor these experiences to their interests and schedule. Participation in a minor experience is not required. A description of options available for minor rotations is presented on page 68. In addition, interns are welcome to create a minor in an area of their interest, pending scheduling and availability of supervision. Minor rotations are discussed after the internship formally begins.

University of Maryland Child Outpatient Psychology Track

Patient Population

The Child Outpatient Program at the University of Maryland School of Medicine consists of rotations in specialized outpatient clinics (Affective Disorders, Trauma), the Taghi Modarressi Center for Infant Study/Secure Starts, and the Maryland Psychological Assessment and Consultation Clinic. Patients seen during these rotations include children from birth to age 18 and their families. Although we see families from diverse ethnic and racial backgrounds, over 75% of patients are of African-American descent.

Assessment and Intervention Training

The 701 Outpatient Rotation will allow the intern to participate two days a week in two specialty clinics (Mood Disorders Clinic and Trauma Disorders Clinic) for children ages 6 to 18. The Child and Adolescent Psychiatry Clinic serves children and adolescents with emotional, behavioral, developmental or learning problems. The Clinic offers a range of services: evaluation, psychological assessment, consultation, and brief or long-term therapy. Treatment includes individual, family and group therapy and parent counseling. Specialized group therapy and multi-family groups are offered for children, adolescents and parents.. There are approximately 5,000 patient visits per year in the Child Psychiatry clinic. Therapeutic modalities include family systems and cognitive behavioral approaches. These are combined with psychopharmacological intervention when indicated. The intern will receive training in several evidence-based treatment models, including Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Strengthening Families Coping Resources (SFCR). Family involvement is emphasized for both diagnostic and therapeutic services. In addition, collaborative working relationships are developed with schools, physicians and other programs and communities. The patient load will include 8 to 10 individual psychotherapy patients in addition to co-leading outpatient groups. The intern will receive individual supervision a minimum of one-half hour per week with Dr. Kiser for work in the Trauma clinic (with the other half-hour devoted to early childhood cases, see below) and one hour per week with Dr. Donohue for work in the Mood Disorders Clinic in order to review cases, provide further intervention training, and establish concrete treatment plans. The intern will also participate in weekly Trauma Clinic Seminar, which will include didactics on trauma-related treatment, case consultation, and group supervision of TF-CBT cases. Weekly group supervision of SFCR groups will also be provided by Dr. Kiser and the SFCR treatment team. Additional supervision will be provided by other clinic staff.

The intern will be placed two days a week in the Secure Starts Clinic within the larger Taghi Modarressi Center for Infant Study (CIS). This placement will allow the intern to specialize in work with children from birth to age five. Secure Starts provides traditional outpatient therapy as well as consultation and more intensive work at the community level. Secure Starts provides multidisciplinary care in an outpatient setting for children from birth to age five with emotional and behavioral concerns. The program encourages active participation of parents and caregivers and works collaboratively with involved agencies. The CIS offers a range of services: diagnostic assessment, psychological testing, consultation, and brief and long-term psychotherapy. Treatment includes individual, family and group therapy, as well as play therapy and parent counseling. Interns will participate in an early childhood mental health consultation project in community settings such as a pre-school setting or a homeless or domestic violence shelter. The patient load will include 8 to 10 individual psychotherapy patients in addition to co-leading outpatient groups. The intern will receive supervision at least one half-hour per week with Dr. Kiser in order to review cases, provide further intervention training, and establish concrete treatment plans for individual patients and their families. The intern will also participate in weekly CIS Clinic Seminar, which will include didactics on early childhood mental health and case consultation. Additional supervision will be provided by other Secure Starts staff.

Both programs for child interns involve interdisciplinary training experiences and the opportunity to work as part of a team. Within the CIS and the Outpatient Rotation, there is opportunity available to be part of various research initiatives.

Support from Literature

Cognitive-behavioral therapy (CBT) is one intervention for childhood PTSD with empirical support. Numerous detailed descriptions of CBT approaches with traumatized children exist (Cohen, Berliner, & Mannarino, 2000; Parson, 1997). Several manualized interventions are available (Deblinger & Heflin, 1996; March, Amaya-Jackson, Murray, & Schulte, 1998). One CBT model, Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), has been studied in numerous randomized, controlled clinical trials (RCT); multiple published studies support its effectiveness (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1996; Cohen & Mannarino, 1996; Cohen & Mannarino, 1997; Cohen & Mannarino, 1998; Cohen, Mannarino, & Knudsen, in press; Deblinger, Steer, & Lippman, 1999). In general, the treatment manualization, control design, training of clinicians, fidelity checks, and follow-up in these studies were exemplary.

Participants in these RCTs included children between the ages of 8 and 17 years; one study focused on 3 to 7 year olds. All of the children experienced sexual abuse. One sample included 229 multiply traumatized children with sexual abuse-related PTSD symptoms. Racial composition of these samples was mixed but predominantly Caucasian. The non-offending parent/primary caretakers participated in all of the trials.

Randomized controlled trials compared TF-CBT (12 weeks) with nondirective supportive therapy (NST), consisting of play therapy for children and supportive therapy for parents, child centered supportive therapy (CCT), and community treatment as usual (TAU). One RCT compared multiple formats of TF-CBT including treatment with child only, mother only, and both child and mother. Results indicated that TF-CBT was significantly better than NST, CCT, and TAU for improving children's PTSD, internalizing, externalizing, and sexual problems. Differences were sustained for up to 24 months. TF-CBT for child and parent was superior to TF-CBT for either parent or child alone. Currently, RCTs of TF-CBT are being conducted on TF-CBT plus sertraline versus TF-CBT plus placebo for 10 to 18 year olds with sexual abuse-related PTSD, TF-CBT versus TAU for children with domestic violence-related PTSD symptoms, and TF-CBT versus treatment without exposure components, 8 versus 16 sessions (K02 MH1938 (Cohen), R01 MH72590 (Cohen), R01 MH64635 (Mannarino)). Given the positive findings across multiple RCTs conducted by several research groups, TF-CBT is labeled an evidence-based practice (Bisson, 2005; Chadwick Center for Children and Families, 2004; Saunders, Berliner, & Hanson, 2004; Substance Abuse and Mental Health Services Administration, 2005).

CBT and medication are the most common forms of treatment for patients in the Affective Disorders Clinic (Hollon, Garber & Shelton, 2005; Kazdin & Weisz, 2003; Lewis, 2003; March, l995; Melvin *et al*., 2006; Rohde, Feeny, & Robins, 2005).

Interns also learn and co-facilitate Strengthening Family Coping Resources (SFCR). SFCR is designed for families living in traumatic contexts with the goal of reducing the symptoms of posttraumatic stress disorder (PTSD) and other trauma-related disorders in children and adult caregivers. Since most families living in traumatic contexts contend with on-going stressors and threats, SFCR is also designed to increase coping resources in children, adult caregivers, and in the family system to prevent relapse and re-exposure. SFCR provides accepted, empirically supported trauma treatment within a family format. SFCR includes additional therapeutic strategies designed to improve the family's ability to cope with on-going stress and threats of re-exposure. Specifically, SFCR builds the coping resources necessary to help families boost their sense of safety, function with stability, regulate their emotions and behaviors, and improve communication about and understanding of the traumas they have experienced. The model includes family work on storytelling and narration, which builds to a family trauma narrative.

Results of implementation trials demonstrate that child posttraumatic stress disorder symptoms are significantly reduced post SFCR by both caregiver- and child-report. Caregivers also report significant reductions in their child's behavior problems. Caregivers report significantly healthier family functioning, improved family coping, and decreased parenting stress. Although further research is essential, SFCR meets its primary intervention goals when delivered in multiple real-world settings.

Interns' individual therapy will be supervised by Dr. Laurel Kiser and Dr. April Donohue, as well as other multi-disciplinary staff, including Ms. Kay Connors, and Ms. Vickie Beck.

The staff in the Secure Starts and Subspecialty Clinics has received extensive training in the use of specific and tested interventions through graduate school education, internship training, postdoctoral training, and specific workshops and training experiences that have enhanced their knowledge and expertise in the treatment of these specific populations and diagnostic conditions.

University of Maryland Baltimore School Mental Health Track

Overview

The University of Maryland School of Medicine and its Center for School Mental Health (CSMH) in Baltimore, Maryland is nationally recognized as a leading interprofessional training program in school mental health (SMH) for psychology, social work, counseling, and psychiatry trainees. UM SOM is the only American Psychological Association (APA) Accredited psychology internship that offers comprehensive major rotation experiences in SMH practice, research, and policy with a goal of preparing scientist-practitioners to work in schools directly with vulnerable and underserved populations. A key mission of the SMH track is to increase the number of psychology interns who pursue careers that help to serve and meet the needs of underserved and vulnerable populations. In 2010 the School Mental Health Internship Track was awarded APA's Award for Distinguished Contributions for the Education and Training of Child and Adolescent Mental Health Psychologists.

The UM SOM SMH Track provides advanced training in SMH practice, research, and policy and is designed to train psychologists in skills to improve access to high quality SMH services and programming (e.g. system-wide prevention efforts, focus on public health concerns), while reducing mental health care disparities. Specifically, SMH Track interns provide a full continuum of mental health services (i.e., mental health promotion, prevention and intervention) to youth and families directly in the community through school- and community-based services. Interns primarily provide this full array of mental health services at two locations, one within their major SMH placement in the UM SOM School Mental Health Program (SMHP) in Baltimore City, Maryland and another minor SMH rotation serving youth in military families (and service-connected civilians) in on-post afterschool and summer programs. In terms of the major SMH rotation, interns provide clinical services to one of many schools in a low-income and highly-stressed urban community predominantly serving minority youth and families in which a large percentage of trainees served have experienced significant trauma. Overall, SMH interns, working with school teams, provide evidence-based intervention, prevention, consultation, assessment, and mental health promotion services to youth across the developmental span with mental health and/or substance abuse disorders.

The comprehensive SMH Track provides a unique opportunity for interns to receive an intensive experience in comprehensive school mental health (SMH) across three critical realms: clinical practice, research, and policy, with a specialty in either early childhood (pre-K) or school-aged youth (K-12). Additional aspects of the program include didactic, research, and policy training in evidence-based practices for diverse youth in underserved and vulnerable schools and communities suffering from complex mental health and/or substance abuse disorders, those exposed to trauma, and those living in military families. Training and supervision are provided by 1) the Center for School Mental Health, 2) the Taghi Modarressi Center for Infant Study (CIS), and 3) The Family Informed Trauma Treatment Center.

Clinical

Interns receive rigorous clinical training across a three-tiered public health framework with major rotations within 1) the UM SMH Program (SMHP) in Baltimore City Public Schools or the CIS Secure Start Program within a Head Start or Early Childhood Center Program in Baltimore City, 2) the Maryland Psychological Assessment and Consultation Clinic (MPACC), and 3) the Fort Meade Military Base Child, Youth, and School Services Program and Army Behavioral Health Program. Interns will complete an intensive clinical rotation (20 hours per week) within a school or early childhood setting in which they provide a full continuum of evidence-based mental health

services to underserved, diverse youth (ages 5-19 years) across a three-tiered public health framework (universal, targeted and selected interventions) in one of the 27 Baltimore City Public Schools (elementary, middle, or high school) or 1 of 2 Head Start Centers. Interns provide evidence-based individual, group, and family therapies; prevention and mental health promotion activities for small groups, classrooms, and school-wide programs; consultation to teachers, staff, and administrators; crisis intervention; and referral to community resources. Additionally, interns conduct assessments at the MPACC throughout the year (6 hours per week). Interns will also conduct universal and prevention activities for trainees in military families during the school year as part of the after-school programming at Fort Meade (3 hours a week for 9 months), and participate in summer prevention groups for trainees in military families through the Army School Behavioral Health Program (6 hours a week for 3 months).

All SMH interns are responsible for coordinating and responding to referrals for mental health services as well as providing the direct services described above. There are also opportunities for participation on school teams and to be involved in the implementation of school-wide mental health promotion and prevention programs to improve the school and early childhood center climate (*e.g.*, violence prevention programs, mentoring, positive behavioral interventions and supports). Primary therapeutic modalities include cognitive behavioral and family systems approaches. These are combined with psychopharmacological intervention when indicated. Family involvement is emphasized for both diagnostic and therapeutic services. In addition, collaborative working relationships are developed with school and early childhood staff, community agencies and programs, advocacy organizations, and other university programs. The patient caseload will include individual and group psychotherapy clients, with an expectation that at least eight trainees are seen per day. The intern will receive supervision of approximately two hours per week with licensed psychologists to review cases, provide further intervention training, and establish concrete treatment plans. Additional supervision and support will be provided by other SMHP leadership representing social work, counseling, and psychiatry fields.

Didactics

The SMH Track promotes interprofessional collaboration and culturally and linguistically competent, evidence-based practice; this curriculum is integrated throughout the internship didactic training. The curriculum is presented throughout the following didactic components: (1) a weekly, cross Consortium seminar (3 hours); (2) a biweekly interprofessional SMH seminar series (90 minutes each); (3) a monthly interprofessional case conference with psychiatry fellows and SMH psychology and social work professionals (1 hour); and (4) specialized intensive trainings (during the summer months, at training events, at conferences, and as part of their rotations). This curriculum is also integrated into individual and group supervision.

As part of the program, psychology, social work, nursing, and psychiatry faculty collaborate to enhance didactics, specialty training in evidence-based practices and programs, training rotations, supervision, and coaching for a predoctoral psychology internship program. Psychology interns participate in didactics with psychology, social work, psychiatry, and nursing trainees and collaborate clinically in schools with educators, mental health and health providers, and community partners. The didactics utilize course instructors and supervisors from multiple professions, and with diverse practice, research, and policy experience, to provide education and training experiences related to SMH, interprofessional collaboration, and cultural and linguistic competency.

Research

Interns are required to conduct an independent research project during their internship year related to addressing the mental health needs of underserved and vulnerable youth and families (5 hours per week). Interns are guided in their selection of a research supervisor, who supports the intern in their conceptualization, design, and completion of their research project, and have a secondary mentor from another discipline besides psychology (e.g., social work, nursing, psychiatry, public health). Interns are required to present the findings to their internship class and research mentors in preparation for sharing their findings with the larger SMH community. Specifically, interns are required to present posters and paper sessions at national conferences and/or publish their findings in peer-reviewed journals.

Policy

Interns participate in the advancement of SMH policy and programming via engagement in a number of CSMH projects, including monitoring of federal, state, and local legislation, development and dissemination of policy briefs, white papers, book chapters, and articles related to SMH policy, writing and dissemination of listservs, and developing resources related to SMH for dissemination to and use by state and local government and agencies (5 hours per week). Interns may also have opportunities to attend policy related meetings and conferences.

Population Served

The SMH Intern serves children between the ages of 5 and 19 years and their families. Although we see families from diverse ethnic and racial backgrounds, approximately 85% to 90% of patients are of African-American descent. Typical presenting problems of trainees receiving individual, group, and family services include: depression, anxiety, posttraumatic stress, disruptive behaviors, family conflict, peer conflict, bereavement, abuse and neglect, family and community violence, substance abuse, and educational challenges.

Support from Literature

Comprehensive school mental health involves the delivery of a full continuum of mental health services and strategies (from mental health education and promotion to intensive intervention) to trainees in both regular and special education, in partnership with families, schools and communities. It builds on existing school programs, services, and strategies and prioritizes the use of high quality evidence-based practices and programs (Weist & Paternite, 2006). In an effort to improve access to care and meet the needs of children, schools have increasingly become a primary site for mental health services and a prevalent service delivery model of mental health care for children and adolescents (Kazak et al., 2010). Further, several national associations, including the American Psychological Association, the American Federation of Teachers, and Mental Health America, as well as numerous researchers and practitioners, have publicly stated support for increasing access to high quality mental health services in schools (Astor et al., 2012). The Center for School Mental Health at the University of Maryland (UMB) School of Medicine (SOM), has been instrumental in the leadership and facilitation of the UM SMH internship program, has been strategically involved in the drafting of a press release and has publicly voiced their support for the adoption of comprehensive school mental health services (Astor et al., 2012). Most recently, a presidential-appointed task force and President Obama have endorsed the need for increased mental health care in schools (White House, 2013).

It is argued that schools are second only to families in shaping children's development (Cowen et al., 1996) and, therefore, make an ideal treatment setting. Because of the co-location of mental health services within a school setting, many of the traditional barriers to care (*e.g.*, access, stigma, and continuity) are significantly reduced allowing for an enhanced access to mental health services for youth (Nabors & Reynolds, 2000). Research indicates that although only 16% of all children receive mental health services, 70 to 80% of those receiving care do so in the school setting (Rones & Hoagwood, 2000).

Integrating mental health services within the school also promotes a natural, ecologically grounded approach to helping children and families (Atkins, Adil, Jackson, McKay, & Bell, 2001). That is, youth and families are able to access services in their own community, providers are able to work with youth in a natural setting, and interventions can be implemented and monitored in an environment where youth are actually experiencing dysfunction. Given this ecologically grounded approach, treatment gains are more likely to be generalized and maintained (Evans, 1999). Some reasons for this improved generalizability include that when providers are based in schools they are better able to observe problem behaviors as they occur rather than rely on retrospective reports, can better manage contingencies in the environment, and can provide better guidance on alternative behaviors that are likely to be successful in the school environment. A priority for the SMH track is the delivery of evidence-based practices and programs in partnership with families, schools, and communities. The CSMH

and its faculty and staff have led clinical research, training and policy efforts to advance best practices related to SMH family engagement (Brandt, N., et al., 2014), workforce development for educators (Gibson, J., Stephan, S., Brandt, N.E., & Lever, N., 2014), education/mental health research (Stephan, S. et al., 2012), and preservice training for clinicians (Lever, N., Lindsey, M., Grimm, L., & Weist, M., 2014).

Given the emphasis on prevention in the school mental health model, the capacity for school mental health providers to engage in prevention and mental health promotion is increased (Weare, 2000). Most, if not all, youth in the school building can benefit from services that highlight healthy and positive behaviors. The presence of school mental health programs has been associated with improved school climate where trainees and teachers reported that they felt they were in a positive learning environment (Bruns, Walrath, Siegel, & Weist, 2004). In addition, Bruns and colleagues (2004) found that SMH has been associated with a reduction in inappropriate special education referrals. Teachers in schools with SMH programs were less likely to refer trainees to the special education eligibility process because of emotional or behavioral problems. The positive effects may be due to a perception that resources are available to support teachers and to help trainees who have emotional and behavioral problems.

An average student enrolled in a social and emotional learning program ranks at least 10 percentile points higher on achievement tests, has better attendance and classroom behavior, likes school more, has better grades and is less likely to be disciplined (Shriver & Weissberg, 2005). In addition to school related outcomes, school mental health programs have also been associated with high service satisfaction by trainees and families (Nabors & Reynolds, 2000). SMH services have been demonstrated to be effective on an individual level and increasingly there is a recognition of the importance of using evidence based programs and practices and effectively documenting outcomes. In a national survey of ESMH programs, 63 percent of respondents reported using evidence based practices as part of their work. Advancing evidence-based practices and programs and developing effective models for supervision, coaching, and training that support evidence-based work is a priority and key research goal of the Center for School Mental Health.

The following centers/programs are affiliated with the SMH internship. Brief descriptions of the programs are provided below.

Center for School Mental Health (CSMH)

The Center for School Mental Health (CSMH) is co-directed by Drs. Sharon Stephan and Nancy Lever. Dr. Nicole Brandt serves as the CSMH Program Manager. The CSMH is the only federally-funded (HRSA) SMH program, research, and policy analysis center. Its mission is to *strengthen policies and programs in ESMH to improve learning and promote success for America's youth*. The Center works at local, state, and national levels to advanced research, training, policy, and practice in SMH. Interns are involved in and lead numerous projects, such as advancing the literature and best practices needed to address trauma, document the quality and effectiveness of SMH services, increase family engagement in mental health services delivered in schools, promote access and meaningful supports for youth impacted by deployments and other issues of military families, and advance the SMH workforce by developing curriculum and training materials. Other opportunities for interns include grant writing (e.g., for federally funded projects, private foundations, and state and local projects), writing book chapters and peer-reviewed journal articles, presenting their work for feedback at the CSMH Writing Group, and critically reviewing articles for leading SMH journals. Additionally, interns have the opportunity to contribute to the ongoing mission of the CSMH through helping to develop practical resources for educators, youth, families, and mental health providers, as well as authoring issue briefs and articles geared toward enhancing the dissemination of best practice and research in SMH.

The Taghi Modarressi Center for Infant Study (CIS)

Founded in 1983 by Dr. Taghi Modarressi, a pioneer in infant mental health, the CIS is currently led by Dr. David Pruitt, Medical Director, and Kay Connors, Program Director. The mission of the Taghi Modarressi Center for Infant Study (CIS) is to provide high quality mental health intervention to young children, and consultation to

families and partners within the early childhood system of care, train mental health professionals and advanced graduate trainees through state-of-the-art coursework and professional development, and support innovation in the field of early childhood mental health (ECMH) through research, program, and policy activities. The CIS serves clients on-site at the UM Secure Starts clinic and also on-site at early education programs (Judy Hoyer Centers and Early Head Start). The interdisciplinary team at the CIS will provide clinical oversight, education, supervision, and coaching related to working with early education programs as well as advancing policy and research related to early childhood mental health. In addition to its Outpatient Mental Health Center, the CIS has provided mental health consultation to early education programs since 1989, and is currently serving three Judy Hoyer Centers, Emily Price Jones Head Start and Maryland Family Network Early Head Start. The CIS also provides consultation to many early childhood programs at the local and state level. CIS staff helps lead state and local committees focused on improving the system of care for ECMH. Since 2008, the CIS has trained 121 post masters-level clinicians in ECMH core competencies and 60 consultants for the District of Columbia and Maryland's ECMH Consultation Project.

School Mental Health Program

The Executive Director of the School Mental Health Program is Dr. Nancy Lever, the Program Director is Mr. Michael Green, LCSW-C, and the Senior Advisor is Dr. Sharon Stephan. The SMHP is a longstanding (established in 1989), interdisciplinary outpatient mental health program that provides high quality comprehensive school mental health services (promotion, prevention, intervention, consultation) to youth and families in 27 Baltimore City schools working in close collaboration with families, schools, and communities. The SMHP has achieved national recognition for its commitment to advance access to high quality mental health care in schools. Baltimore was among the first nationally to develop school-based health centers, and has become a leader in the systematic development of comprehensive school mental health programs. The SMHP staff is comprised of licensed social workers, professional counselors, psychologists, and graduate trainees (social work, psychology, counseling, psychiatry, nursing). The SMHP is one of four lead programs in Baltimore City providing SMH services. SMH services augment the work of school-employed mental health providers, are available to youth in both general and special education, offer a full continuum of mental health services within the school, and are intended to reduce barriers to learning and promote student success. The SMHP is committed to implementing evidence-supported practices and programs across the Public Health Triangle. With many faculty within the SMHP having expertise in several evidence-based practices and programs (e.g., Modularized Practice/Common Elements, Coping Power, CBITS, FRIENDS), there are numerous opportunities for specialized training and skill practice.

Baltimore City Head Start Program/Early Childhood Centers

The Head Start/Early Childhood Centers missions are to promote school readiness and family self-sufficiency through a full continuum of services from mental health promotion to more intensive intervention. These programs nurture and respect the individual strengths and areas for growth in each child and family served. An emphasis is placed on engaging parents in all aspects of the program and helping them to realize their full potential in order to enhance the long-term benefits of the program. Strong, supportive relationships and extensive community partnerships have been established to support families' goal attainment.

As part of the early childhood SMH rotation interns will provide services and programming across the public health continuum. Examples of service provision include:

School Wide Activities

The intern will distribute information to support healthy development and social emotional wellness for trainees, families and school staff. School staff trainings on the effective use of Social and Emotional Foundations for Early Learning (SEFEL) strategies and tools in the classroom, as well as, educate families on the use of SEFEL's strategies and tools to use at home will be conducted. In addition**,** the intern will conduct Strengthening Families Coping Resources workshops designed to optimize family functioning by increasing use of rituals and routines to manage stress.

Group Prevention Activities

The intern will complete classroom and mental health observations and use Devereux Early Childhood Assessment (DECA) child-specific and classroom tools to develop appropriate prevention activities to promote wellness in children and the teacher' capacity to support social emotional development. The clinicians will consult with teachers and caregivers of children identified as having concerns and use SEFEL strategies and tools and will support the implementation of Second Step in classrooms.

Assessment and Treatment Services including Transition Activities

HS clinicians will collaborate with the HS disability coordinator to assess children for social, emotional, and behavioral concerns. Based on the assessment, the team will develop intervention plans using DECA and SEFEL strategies and tools. The clinicians will coach teachers and caregivers on implementation of recommended strategies and monitor progress through assessments, meetings and observations. For families consenting to treatment, the clinician will complete a diagnostic evaluation and will conduct parent-child, individual, group and multifamily group therapies as indicated and participate in fee-for-service as appropriate

Training and Consultation Services

The HS clinicians will train and coach teachers to administer the DECA assessment and strategies, SEFEL modules, strategies and tools and Second Step curriculum. In addition, the teams will educate families about what SEFEL is and will consider with families what tools and strategies could be used at home to help reinforce the strategies in school.

Individual and small group supervision will be provided by Drs. Kimberly Becker, Jill Bohnenkamp, Dana Cunningham, Nancy Lever, Sharon Stephan, and Catharine Weiss, all licensed psychologists with significant experience related to school mental health, military families, and/or youth with trauma exposure.

The Family Informed Trauma Treatment Center (FITT)

The director of the Family Informed Trauma Treatment Center (FITT) Center is Dr. Laurel Kiser, the mission of the FITT Center is to develop, implement, evaluate, and disseminate family-based interventions for urban and military families to support positive outcomes for children and families who have experienced chronic trauma and stress. The FITT Center is part of the National Child Traumatic Stress Network (NCTSN) and one of 15 Category II Centers nationwide. In 2000, under the leadership of the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS), the NCTSN was established to raise awareness of the impact of childhood trauma and increase access to effective trauma treatments for thousands of our nation's children and adolescents. NCTSN chose the FITT Center to serve as a national expert on the role of families in the lives of children impacted by trauma and to further the availability of effective family trauma treatments. The FITT Center will lead the education, training, supervision, and coaching of clinicians related to effective family informed trauma treatment for children and adolescents, including intensive training and coaching in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Strengthening Families Coping Resources (SFCR). Supervision related to TF-CBT will be provided by Dr. Kiser and/or Ms. Beck.

Child Psychology: Maryland Psychological Assessment Clinic Rotation

Patient Population

All child interns participate in the Maryland Psychological Assessment and Consultation Clinic (MPACC) which offers a year-long experience providing assessment and consultation services to children and adolescents served through outpatient programs within the University of Maryland. Interns will spend approximately six hours per week in this clinic. Their time will be devoted to participating in training and supervision, conducting psychological assessments of children and adolescents (ages 2 to 18), conducting daycare/school observations, consulting with school and treatment staff, scoring, interpreting and writing reports, and providing feedback to families and treatment teams. Each intern will be responsible for approximately 6 assessments over the course of the year. Clients are typically referred to MPACC from child and adolescent mental health programs in the University of Maryland System, including the 701 Outpatient Clinic, the School Mental Health Program, and the

clinic that serves families of university employees.

Assessments & Supervision

MPACC referral questions are very diverse and can include differentiating between the breadth of clinical disorders and screening for learning problems, and making recommendations for school and treatment services. Tests administered include, but are not limited to: Autism Diagnostic Observation Schedule-2 (ADOS), NEPSY-II, Wechsler Intelligence Tests (WPPSI-IV, WISC-V, and WAIS-IV), Wechsler Individual Achievement Test-III, and Woodcock Johnson IV - Tests of Achievement, Vineland Adaptive Behavior Scales, and a wide variety of behavior checklists. Feedback sessions involve the family and referring clinicians and emphasize the strengths and needs of the children and families.

During the first two months of internship interns will complete training in the Autism Diagnostic Observation Schedule-2 (ADOS) and spend time practicing the assessment. Interns will also have other targeted trainings during the year on assessment topics. Jill Bohnenkamp, Ph.D. and Catharine Weiss, Ph.D. will provide weekly supervision of interns and co-lead diagnostic interviews and feedback sessions with interns and review and provide feedback on assessment reports. Additional supervision and support, particularly related to early childhood assessment, will be provided by Rebecca Vivrette, Ph.D.

UM Child Supervisors' Training & Experience

Vickie Beck, A.P.R.N., B.C., is currently a lead clinician in the Child Subspecialty Clinics. She has almost over 35 years of experience as a clinical nurse specialist working with abused children and their parents. She is a nationally certified TF-CBT trainer, leading training and ongoing coaching for licensed clinicians and University of Maryland child and adolescent trainees. Ms. Beck provides trauma focused supervision and support to all child interns.

Kimberly Becker, Ph.D., is a Clinical Supervisor for the SMHP and is an Assistant Professor in the Department of Psychiatry. Dr. Becker received a Bachelor's Degree in Psychology from the College of William & Mary. She then completed her Doctorate in Psychology at the University of Arizona, a Respecialization Certificate in Clinical Psychology at the University of Hawaii, and postdoctoral fellowships at the Johns Hopkins Schools of Medicine and Public Health. Dr. Becker joined the faculty of the University of Maryland School of Medicine in 2012. Dr. Becker's clinical experience and research have focused on improving the effectiveness of evidence-based prevention and treatment interventions for children and adolescents through innovations in provider training and clinical decision-making. Through this work, Dr. Becker has collaborated with therapists, teachers, and paraprofessionals to increase youth and family participation in services and enhance service quality across a variety of settings.

Jill Bohnenkamp, Ph.D. is an Assistant Professor at the University of Maryland School of Medicine and Center for School Mental Health. She received her Ph.D. in Clinical and School Psychology from the University of Virginia, Curry School of Education in 2012. Dr. Bohnenkamp completed her pre-doctoral internship at Children's National Medical Center in Washington, D.C., and postdoctoral fellowship at the national Center for School Mental Health at the University of Maryland School of Medicine. Dr. Bohnenkamp provides clinical assessment supervision in the Maryland Psychological Assessment and Consultation Clinic (MPACC) and individual and group clinical, research and policy supervision to school mental health and early childhood school mental health interns. Dr. Bohnenkamp's research interests focus on behavioral and academic outcomes of school mental health service provision, school mental health workforce development, mental health training for educators and pediatric primary care providers and increased access to mental health services for youth and families.

Elizabeth Connors, Ph.D., is a Research Associate at the University of Maryland School of Medicine and Center for School Mental Health. She received her Ph.D. in clinical psychology, with concentrations in community and child psychology, from the University of Maryland Baltimore County in 2014. Dr. Connors completed her pre-doctoral internship in the School Mental Health Track of the VAMHCS/UM SOM Psychology Internship

Consortium, and currently provides supervision and support to interns on research, policy and practice activities within the Center for School Mental Health, including providing guidance on intern research projects. Dr. Connors' research interests focus on dissemination, implementation and program evaluation of evidence-based mental health services for children and families receiving care in school and community-based settings.

Kay Connors, L.C.S.W., is the Program Director of the CIS and a senior clinician in the Trauma Clinic, and has over 20 years of experience working with traumatized children and their families. Ms. Connors has provided mental health treatment to children and families in a variety of settings, including hospital, residential treatment, private practice, clinic, and home-based programs. Ms. Connors has directed programs, supervised staff, participated in outcome research as well as trained trainees and audiences locally and nationally.

Dana Cunningham, Ph.D., is the Coordinator of the Prince George's School Mental Health Initiative (PGSMHI) and is involved in intern research and training. The PGSMHI is designed to provide intensive school-based counseling and supports to trainees in special education. Dr. Cunningham graduated from Southern Illinois University at Carbondale with a doctoral degree in Clinical Psychology in 2004. Following the completion of her internship at the VAMHCS/UM SOM Psychology Internship Consortium, she completed a two-year postdoctoral fellowship at the Center for School Mental Health. She is currently an Assistant Professor in the Department of Psychiatry. Dr. Cunningham's research and clinical interests are in the area of resilience, empirically supported treatments for ethnic minority youth, and school mental health.

April Donohue, Ph.D., received her Ph.D. in clinical psychology from Northern Illinois University in 2011. She completed her clinical internship at the University of Maryland School of Medicine, and then joined the staff of the child outpatient clinic in 2011. She provides services to children and families in the child outpatient clinic, and also provides teaching and supervision to trainees in the Division of Child and Adolescent Psychiatry. Dr. Donohue supervises the child outpatient intern's cases (typically 4-6) in the Mood Disorders clinic, which includes both mood and non-trauma anxiety cases.

Laurel Kiser, Ph.D., M.B.A., received a Ph.D. in psychology from Indiana University and a M.B.A. from the University of Memphis. She completed internship and two years of post-doctoral training in child clinical psychology. She is an Associate Professor in Psychiatry at UMB. Dr. Kiser's career focus has been on the provision and evaluation of treatment for youth living in poverty, victims of neglect, physical and sexual abuse, with moderate to severe psychiatric and behavior disorders. Her research is on the protective role of rituals and routines for coping with trauma and she is supported by an NIMH K-23 Award for developing a manualized, multi-family skills-based intervention for traumatized families. Dr. Kiser is co-Principal Investigator of the National Child Traumatic Stress Initiative Category II Family Informed Trauma Treatment (FITT) Center. Clinically, she co-directs the Trauma Clinic and serves as the Psychologist supervisor for the Center for Infant Study. Dr. Kiser is also active in teaching and supervising Division trainees on childhood trauma in multiple venues. She provides trauma education in community settings for clinicians on assessment and treatment of young children impacted by violence exposure.

Nancy Lever, Ph.D., is the Co-Director of the Center for School Mental Health, Director of the University of Maryland School Mental Health Program, and an Associate Director of the VAMHCS/UM SOM Psychology Internship Consortium. She completed her undergraduate degree in psychology at Dartmouth College and her doctoral training in clinical psychology at Temple University. She completed her child internship and SMH postdoctoral training at the University of Maryland School of Medicine before joining the Department of Psychiatry in 1998. She is an Associate Professor in the Division of Child and Adolescent Psychiatry. She has been very active in promoting training related to SMH and has coordinated training experiences for psychology interns, psychiatry fellows, and postdoctoral fellows. She has presented and written extensively about school mental health. Research interests include: quality assessment and improvement, dropout prevention, workforce development, school transitions, and promoting resiliency. She oversees the SMH track and provides clinical supervision and training.

Sharon Hoover Stephan, Ph.D., received her Ph.D. in clinical psychology from the University of Maryland Baltimore County in 2002, completing her clinical internship and two-year postdoctoral fellowship at the University of Maryland School of Medicine at the Center for School Mental Health (CSMH) and the School Mental Health Program. She is the Co-Director of the CSMH and an Associate Professor in the Department of Psychiatry. Dr. Stephan's clinical and research focus is in the implementation of empirically-supported interventions in schools, with a particular emphasis on serving traumatized youth and youth from health-disparate populations. She conducts research and clinical training in the areas of mental health-primary care collaboration and integration, quality assessment and improvement, co-occurring disorders, school transitions, and trauma. She provides research and clinical supervision within the SMH track.

Rebecca Vivrette, Ph.D., is a Postdoctoral Fellow in the Division of Child and Adolescent Psychiatry. She received her doctorate degree in Clinical Psychology from the California School of Professional Psychology in 2014. She specializes in early childhood mental health clinical treatment, assessment, and research. She has significant training and experience in early childhood trauma. She is assisting the assessment team with clinical support for the interns and is providing expertise in early childhood assessment. She serves as the Coordinator of the Graduate Psychology Education grant under Dr. Lever. She conducts research related to early childhood mental health and traumatic stress and also has been evaluating and the impact of maternal health and mental health on child development.

Catharine Weiss, Ph.D., is the Director of the Maryland Psychological Assessment and Consultation Clinic (MPACC) and a Clinical Assistant Professor in the Department of Psychiatry. She received her Ph.D. in clinical/community-social psychology from the University of Maryland, Baltimore County in 2004. She completed her clinical internship and two-year postdoctoral fellowship in school mental health at the University of Maryland School of Medicine. She also delivers direct intervention and prevention services across a range of settings, including providing collaborative care for children, families, and adults in a neighborhood primary care clinic and supervising staff in schools and a hospital to school transition program. Her research focus is on behavioral health and primary care collaboration and supporting successful transitions of hospitalized youth to their school and community. Dr. Weiss provides clinical supervision and training related to child and adolescent assessment and also provides supervision within the SMH track.

Minor Rotations

We offer several minor rotations which vary in their duration and workload. The specific minors that are offered vary from year to year, depending on staff resources and institution needs.

Diversity Minor

Introduction

The Diversity Minor Rotation was developed in the spirit of integrating diversity more fully into the training experience. As psychologists, we are tasked with the ethical responsibility of providing culturally informed and appropriate treatments for our clients and the communities with which we engage. However, clinicians often cite concerns about their abilities to apply knowledge of diversity to daily practice. This minor rotation will provide interested interns an opportunity to bridge the gap between knowledge and application.

Core Components

The Diversity Minor Rotation was designed to be flexible, allowing interested interns an opportunity to create an experience fitting with personal and professional goals, prior training experience, and expectations. This is also consistent with a multicultural psychology approach, in which the client is seen as an expert collaborating in their treatment. Generally, though, an intern would participate in this

rotation for a period of six months to a year and approximately three to six hours per week. Core components include the following:

1. *Development of a year-long project, culminating in a presentation for your peers, supervisors, and VA psychologists.* The nature of this project will be determined by the intern in collaboration with the rotation supervisor, but may include an administrativeproject, consultative service, clinical training delivery, psychotherapeutic intervention, development of a paper, program evaluation/needs assessment, etc.
2. *Participation in the VAMHCS Mental Health Diversity Committee.* This multidisciplinary committee aims to integrate diversity into the spectrum of activities in which VAMHCS mental health employees engage.
3. *Maintenance of the VAMHCS Virtual Cultural Resource Center (VCRC).* The VCRC is an on-line database consisting of seminal diversity and multicultural literature and resources, which is made available to VAMHCS Mental Health staff.

Objectives

Upon completion of the Diversity Minor Rotation, interns will understand more deeply the necessity for a more inclusive practice of psychology. Interns will have working knowledge of the general concerns within the field of multicultural psychology as well as specific challenges implementing culturally-based approaches to treatment and research in a large medical setting. Interns will have developed a particular skill-set in the application of multicultural psychology, as a result of participation in supervision and developing a specific expertise with regard to their year-long project.

Supervision

Supervision will be conducted using a motivational enhancement and multicultural approach, emphasizing how best to apply empirically supported treatments to a diverse, urban population. The frequency and intensity of supervision will vary, based on the intern's level of experience and training. An intern would be expected to meet for face-to-face supervision once a week for one hour; administrative or research projects may be less frequent, depending on need and developmental level of the trainee. Spot supervision will be available as well.

Supervisor's Training and Experience

Dr. Jade Wolfman-Charles, a VAMHCS Supervisory Staff Psychologist and the Psychology Training Program Director, completed her degree in Clinical and Community/Social Psychology at the University of Maryland, Baltimore County. Her research focused on individual and community level risk and protective factors of substance use with a specific focus on African Americans. Dr. Charles has specialized training in evidence based practices including Cognitive Behavioral Therapy, Motivational Enhancement Therapy, Acceptance and Commitment Therapy and Cognitive Processing Therapy and serves as a Consultant for the VA National Motivational Interviewing Initiative.

Dr. Erika White completed her graduate training at Saint Louis University, obtaining a Ph.D. in Clinical Psychology. Her dissertation research addressed the perpetration of racial microaggressions in a cross-racial counseling dyad. Her predoctoral internship was completed at the Washington, D.C. VAMC. She completed ten months of a postdoctoral fellowship at the Pittsburgh VA from October 2010 to August 2011. Dr. Morton has worked as a staff psychologist in the Trauma Recovery Program since August 2011. Since this time, she has become coordinator of the PTSD Assessment Clinic and has worked with colleagues to implement the VAMHCS Mental Health Diversity Committee and Diversity Seminar Series. Dr. Morton greatly values training and enjoys the supervision of trainees from all levels. She continues to be interested in increasing the multicultural awareness of trainees and staff and offering evidence-based psychotherapy to Veterans diagnosed with PTSD.

EFT Couples Therapy Minor

The minor rotation is designed to give interns the opportunity to learn an empirically supported approach to working with couples. Interns will learn Emotionally Focused Couples Therapy (EFT) developed by Sue Johnson, Ed.D. This evidenced based treatment is based on the integration of attachment theory, humanistic psychology and systems theory. During the summer, interns will discuss EFT literature, use the EFT training workbook, review and discuss professional training tapes and will develop and practice skills thru small group discussion and role plays. During the course of the year, the clinician will work with one or two couples. There will be weekly group supervision and scheduled individual supervision. Supervision modalities include discussion of the case and review of videotaped sessions. The minor requires an intern to commit to 5 hours a week for a full year. The treatment population will be couples who have the psychological resources to benefit from this course of treatment. These Veterans will usually be relatively higher functioning and may have a wide range of possible diagnoses.

Supervisors' Training & Experience

Dr. Neil Weissman has been an attending psychologist for the VA since 1992 and has supervised interns for these 19 years. He has completed a post-doctoral fellowship in the treatment of SMI from Sheppard Pratt and has received specialized training in CBT from the Beck Institute in Philadelphia. Dr. Weissman is also a certified supervisor in Emotionally Focused Couples Therapy from the International Center for Excellence in Emotionally Focused therapy.

Minor Rotation in Family Intervention Team (FIT)

This minor rotation is designed to offer psychology interns the opportunity to develop competencies in working psychotherapeutically with families and couples within a number of evidence-based practice frameworks. Interns participating in this minor rotation can expect to master utilization of the following evidence based family therapy practices officially endorsed and widely utilized by the VA system nationally: Integrative Behavioral Couple Therapy (IBCT), Behavioral-Couples Therapy for Substance Use Disorders (BCT-SUD), and Behavioral Family Therapy (BFT).

Integrative Behavioral Couple Therapy (IBCT) was developed and empirically validated by Drs. Andrew Christensen and Neil Jacobson (2000) to promote the dual goals of greater emotional acceptance and concrete change as positive outcomes for couples. IBCT boasts a variety of treatment strategies tailored for each couple based on a rich and textured case conceptualization developed within the assessment phase of treatment. During the formal treatment phase, strategies to promote acceptance and change are consistent with other behavioral treatments, yet are elegantly evocative in nature rather than prescriptive. Couples who engage in IBCT tend to make concrete changes to accommodate the new acceptance they've gained of their partners' emotional needs.

Behavioral Couples Therapy for Substance Use Disorders (BCT-SUD) is a first-line treatment for substance use disorders according to VA/ DoD practice guidelines. Developed by Drs. Timothy O'Farrell and William Fals-Stewart (2006), BCT-SUD has demonstrated within randomized studies, compared to individual treatment alone, that it leads to significantly greater substance use treatment outcomes and facilitates greater relationship adjustment following treatment. BCT-SUD is designed to offer, within its structured 12-session protocol, additional support for sobriety, increased relationship satisfaction, and instruction on effective communication skills.

Behavioral Family Therapy (BFT) was designed by Drs. Kim Mueser and Shirley Glynn (1999) specifically to offer support, psychoeducation, and communications skills training for families and their loved ones who've been diagnosed with a Serious Mental Illness. This intervention has demonstrated within empirical studies significant reductions in psychiatric symptoms, increases in quality of life for both the identified patients and their families, and improvements in family cohesion.

Other FIT treatment modalities in which psychology interns may have the ability to gain some experience within the training year include: Brief Family Consultation (1 – 3 session intended to determine family needs and offer recommendations); Parenting Training educational classes (utilizing a curriculum developed by the Military Child Education Coalition/ MCEC); Cognitive-Behavioral Couples Therapy for PTSD (developed by Dr. Candace Monson); and Structured Approach Therapy for OEF/ OIF Veterans with PTSD (developed by Dr. Frederic Sautter).

Psychology interns will meet individually with Dr. Korobkin for 1 hour of supervision at least once a week and are expected to audio tape sessions from at least 2 IBCT cases and 1 BCT-SUD case during the training year. Dr. Korobkin will then be able to offer specific feedback on these tapes within the supervision. There are also opportunities for the following: Additional group supervision (with FIT psychology extern and Dr. Korobkin), case presentations within the FIT weekly team meetings, video recording of sessions and Live Supervision (as possible).

Supervisor's Training and Experience

Samuel B. Korobkin, Ph.D. is the Coordinator of the Psychology Externship Program at the VA Maryland Health Care System (VAMHCS) and provides direct care services to Veterans and their families as the full-time clinical psychologist for the VAMHCS Family Intervention Team (FIT). He also serves as a VA Central Office national consultant for the Integrative Behavioral Couple Therapy (IBCT) evidence based practice roll out initiative. As such, he offers consultation and certification to VA licensed independent practitioners nationally in the provision of IBCT services. He is further serving as a Subject Matter Expert and consultant for the VISN5 MIRECC Wellness Recovery Action Planning (WRAP) pilot study. Additionally, he maintains a part-time private practice providing adult individual and couples psychotherapy. Dr. Korobkin completed his Bachelor's degree at University of Maryland Baltimore County, and his Master's and Doctorate degrees in Clinical Psychology from St. John's University in New York. He completed a pre-doctoral internship at the Baltimore VA Medical Center and a post-doctoral fellowship at the West Los Angeles VA Medical Center. He has worked in various medical and private practice settings both in California and Maryland and has served as a clinical supervisor for psychology interns and externs. Dr. Korobkin' s specific clinical interests include couples and family psychotherapy and recovery-oriented interventions.

Long Term Psychoanalytic Supervision Rotation

The minor rotation in long term psycholoanalytic supervision is designed to provide a year-long experience in structured supervision in the conceptualization and treatment of long term clients from a psychoanalytic perspective. Interns will see at least one patient throughout the year, and participate in one hour of supervision with a licensed clinical psychologist. Clients are provided through referrals through the Mental Health Clinic. Supervision occurs at the Baltimore VA Medical Center, on Tuesday evenings; therefore, interns interested in this minor must commit to Tuesday evening supervision appointments and limited telephone supervision.

Supervisor's Training & Experience

Dr. Mark Nolder received his Ph.D from Texas Tech University in 1990. He completed a clinical internship at the Audie L. Murphy VA Medical Center in San Antonio, Texas. He is currently a staff psychologist in the outpatient program at the Fort Howard Community Based Outpatient Clinic. He is also an Adjunct Professor at Towson University and has his own private practice in Harford County. Dr. Nolder's research and clinical interests include: Psychoanalytic metapsychology, evidence-based psychoanalytic psychotherapy, evidence based psychotherapy relationship factors, psychotherapy supervision, psychology of music, individual psychoanalytic psychotherapy.

Mindfulness-Based Interventions

Mindfulness-Based Stress Reduction (MBSR) is an eight-week, group-based protocol that has been shown to be an effective treatment for chronic pain and stress (Kabat-Zinn, Liworth, Burney, & Sellers, 1986), anxiety disorders (Miller, Fletcher, & Kabat-Zinn, 1995), and other chronic mental health conditions. Mindfulness-Based Cognitive Therapy has been shown to reduce the likelihood of experiencing future major depressive episodes for individuals who have experienced three or more major depressive episodes prior to receiving MBCT (Teasdale et al., 2000; Ma & Teasdale, 2004). Recently, King, Erikson, Giordino, et al. (2013) have demonstrated that a version of MBCT adapted for use with combat Veterans experiencing symptoms of PTSD significantly reduced symptoms of PTSD, indicating that it may be a promising intervention for this condition.

This twelve month, minor rotation is an opportunity for interns and post doctoral fellows to receive intensive training in mindfulness-based interventions including (MBSR), Mindfulness-Based Cognitive Therapy for Depression (MBCT), and Mindfulness-Based Trauma Recovery (MBTR). Please note that this minor rotation will entail significant experiential training in mindfulness techniques and trainees will be asked to make a commitment to develop a personal mindfulness practice. Dr. Andy Santanello and Dr. Joshua Semiatin will be the primary supervisors for this training experience which will include the following elements:

Participation in a Mindfulness-Based Stress Reduction (MBSR) class led by Dr. Santanello and Dr. Semiatin
Trainees will attend eight, two hour MBSR classes and a half-day silent mindfulness retreat in which they will experience mindfulness practice for themselves. During the course of this class, trainees will learn and practice all of the core mindfulness techniques included in the mindfulness-based "family" of interventions. Through experiential practice of mindfulness in class and at home as well as didactic instruction, trainees will deepen their ability to bring mindful awareness into their personal and professional lives. Trainees will be strongly encouraged to practice mindfulness on their own between classes.

Collaborative Teaching of an MBSR Class
Upon completing their own MBSR class, interns will then take turns teaching an MBSR class to each other and to postdoctoral fellows who elect to begin this rotation in September of the training year. These "teach backs" will afford trainees an invaluable opportunity to practice their skills in facilitating mindfulness exercises and practicing mindful inquiry, a core skill in mindfulness-based interventions. The "teach back" method of training is the same process used in intensive MBSR and MBCT teacher training. During this phase of training, Dr. Santanello and Dr. Semiatin will take on the role of a participant-guide, offering feedback to trainees from both the perspective of a learner being taught mindfulness skills by the trainees and the perspective of a supervisor. Trainees will be strongly encouraged to practice mindfulness on their own between classes.

Participation in Mindfulness Practice and Supervision Group
Once trainees have completed collaborative teaching of an MBSR class to each other, all trainees will meet with Dr. Santanello and Dr. Semiatin for group mindfulness practice and supervision once per week. This time will be used to practice mindfulness skills in a group setting, to review the content of the MBSR protocol (and other mindfulness-based protocols), to practice conceptualization of various presenting problems using a mindfulness-based approach, and preparing to implement MBSR with Veterans. Trainees will be strongly encouraged to practice mindfulness on their own between classes.

Collaborative Teaching of Mindfulness-Based Intervention to Veterans
Trainees will apply the skills they've learned through personal practice and by teaching their fellows trainees by co-leading mindfulness classes for Veterans with Dr. Santanello, Dr. Semiatin, and/or another psychologist in VAMHCS. Interns will be expected to co-facilitate the Trauma Recovery Program

Mindfulness Practice Group (Wednesdays, 1-2pm) on a regular basis as their schedule permits. In addition, interns will be strongly encouraged to co-facilitate at least one closed mindfulness group (e.g., MBSR) during the training year.

Development of a Mindfulness-Based Professional Development Project
Trainees will be encouraged to find new and creative ways to apply mindfulness-based skills and interventions to their professional lives. Through consultation with Dr. Santanello and Dr. Semiatin, each trainee will identify an area of professional life in which he or she perceives an application for mindfulness. The trainee will then plan and implement a small project designed to apply some aspect of mindfulness to this area of interest. Examples include making information about mindfulness and mindfulness-based approaches available to other providers or starting a mindfulness practice group.

Supervisor's Training and Experience
Andy Santanello, Psy.D. is the Team Leader for the Serving Returning Veterans Mental Health Team (SeRV MH) at the Baltimore VA Medical Center. He provides direct care to Veterans receiving services as a clinical psychologist for the SeRV MH and the PCT. Dr. Santanello is recognized as a VA certified provider of Prolonged Exposure Therapy, Cognitive Processing Therapy, and Cognitive Behavior Therapy for Depression and served at the Evidenced-Based Psychotherapy Coordinator for VA Maryland Health Care System (VAMHCS) from 2009-2011. He has received intensive training in Acceptance and Commitment Therapy and Mindfulness-Based Cognitive Therapy for Depression. In addition to a professional commitment to evidence-based psychotherapy and mindfulness-based interventions, Dr. Santanello has a strong, personal commitment to mindfulness practice in his personal life. Dr. Santanello completed his Bachelor's degree at Manhattan College, and his Master's and Doctorate degrees in Clinical Psychology at La Salle University. He completed both a pre-doctoral internship and a post-doctoral fellowship at the Baltimore VA Medical Center. He has been an employee of the VAMHCS since 2005 and has served in several capacities since that time.

Josh Semiatin, Ph.D earned his doctorate in clinical psychology from the University of Maryland, Baltimore County. He completed his pre-doctoral internship at the Albuquerque VA Medical Center, with an emphasis on Evidence Based Therapies for PTSD and dual diagnosis, couple therapies, and assessment. Dr. Semiatin also completed a two-year clinical practicum at Advocates for Survivors of Torture and Trauma, a non-profit clinic in Baltimore focused on PTSD recovery among asylum-seeking immigrants. Prior to joining VA Maryland, Dr. Semiatin served as staff psychologist in the VA Pittsburgh's Combat Stress Recovery Clinic. His clinical interests include CBT for PTSD, Acceptance and Commitment Therapy, conjoint/couples treatments for Veterans with trauma histories, anger and aggression, diversity issues in psychotherapy, and psychological assessment. His research has focused on the impacts of trauma and PTSD on anger and aggression, particularly intimate partner violence (IPV) and childhood physical abuse. His publications include scientific articles related to violence prevention, as well as a book chapter on motivational interviewing for partner-violent men, and he has presented symposia at national research conferences, including those of the Association of Behavioral and Cognitive Therapies and the Pediatric Academic Societies.

Sexual Offenders Clinic

The Special Offenders Clinic at the University of Maryland School of Medicine provides evaluation and treatment for sexual offenders who have been referred to treatment as a condition of their parole or probation. The Clinic operates only on Tuesday evenings. Interns are required to attend from 4:45 to 6:45, during which they will attend the staff's team meeting, or evaluate offenders for admission into the program, and cofacilitate one group. Interns will learn how to evaluate, conduct standardized risk assessments, and do treatment with sexual offenders. Interns do not conduct individual interviews with offenders until they indicate they are comfortable doing so.

Supervisor's Training and Experience

Dr. James Fleming received his Ph.D. in Clinical Psychology from the California School of Professional Psychology, San Diego in 1995. For the past 17 years he has worked in forensics and corrections and made many presentations on the risk assessment and treatment of sex offenders and violent offenders. In addition to working at the Special Offenders Clinic, he is Psychology Services Chief at Patuxent Institution, Maryland's treatment-oriented maximum security prison, and an advisor to the Governor's Sexual Offender Advisory Board.

Telemental Health

The primary setting for this rotation is virtual. While stationed at Baltimore, the Baltimore Annex, Loch Raven or Glen Burnie, psychology interns will meet with Veterans in the Tele Mental Health (TMH) program. Therapy sessions will occur via video teleconference to one of two VA Community-based Outpatient Clinics (CBOC) 1.) the Cambridge CBOC; and/or 2.) the Pocomoke CBOC, both located on the Eastern Shore of Maryland. The Eastern Shore CBOCs are staffed by psychologists, psychiatrists, medical and mental health social workers, physicians, nurse practitioners, and a pharmacist. Mental Health services are integrated into the primary care clinic. The role of the supervising psychologist within the TMH program is to provide Specialty Mental Healthcare related to PTSD/SUDS. However, the intern may also have the opportunity to work with patients struggling with more general mental health conditions. In addition, this rotation affords interns the opportunity to work as part of an integrated healthcare team, directly interacting with both primary and mental healthcare providers, as well as staff specifically designated to TMH services.

Veterans seeking care at the Cambridge and Pocomoke CBOCs are generally high functioning, motivated and employed or retired. Interns will have the opportunity to work with both male and female Veterans, who live in a rural setting and who have mental health issues that are sometimes exacerbated by issues associated with rural living. The Veterans are generally 18 and older and varied in their ethnic and racial backgrounds, with the majority being Caucasian. Interns can expect to gain experience with a variety of diagnostic and treatment issues, including PTSD, Substance Use Disorders (the most common substances of abuse among these Veterans include alcohol, marijuana, prescription drugs, and some use of cocaine and heroin); Depression, Anxiety, and Bipolar Disorder. Actively psychotic and/or suicidal Veterans are not generally seen via TMH. However, in the event that a patient becomes suicidal, support staff and licensed providers on the patient side are readily available to assist with emergencies.

During this rotation, interns will function as an integral part of a TMH team, which includes the attending prescriber, the supervising psychologist, the TMH psych tech, and the TMH health tech. The intern will serve as the primary therapist for Veterans seeking treatment for one or more diagnoses, including severe substance use disorder, PTSD, mood disorders, and other mental illnesses. Training and supervision may include didactics and hands-on exposure to the following evidenced-based therapies:
During this rotation, interns will function as an integral part of a TMH team, which includes the attending prescriber, the supervising psychologist, the TMH psych tech, and the TMH health tech. The intern will serve as the primary therapist for Veterans seeking treatment for one or more diagnoses, including substance dependence, PTSD, mood disorders, and other mental illnesses. Training and supervision may include didactics and hands-on exposure to the following evidenced-based therapies:

g. The basics of the TMH modality, including the TMS training that is required prior to providing TMH services.
h. The fundamentals of the Motivational Interviewing approach to treating addictions (MET; Miller and Rollnick, 1991), particularly as it applies to the phase of change model of motivation (Prochaska, Diclemente, and Norcorss, 1992).
i. The tenets of exposure-based therapies for the treatment of PTSD and other anxiety disorders, including the use of Prolonged Exposure Therapy via TMH (Foa, Hembree, Rothbaum, 2007; Craske and Barlow, 2007)

j. The essentials of Cognitive Behavioral Treatment (Beck, A., 1979; Beck, J., 1995;)
k. The fundamentals of Seeking Safety therapy for the concurrent treatment of PTSD/SUDS (Najavits, L., 2002)
l. The use of Mindfulness approaches to treat depression, anxiety, and other mental health disorders (Segal, Williams, Teasdale, 2002; Linehan, 1993; Hayes, 2005).

Ideally, interns will do a year-long rotation in the TMH minor rotation, however, shorter rotations may be possible. Interns will carry an individual patient caseload, and possibly conduct group therapy via TMH as the TMH program expands (currently there are no TMH groups). Interns will conduct full psychosocial assessments to include the diagnosis of and differentiation between substance use, abuse and dependence disorders; the distinctions between PTSD, GAD, Depression, other Anxiety Disorders, and TBI; and differentiate and understand co-morbidity and the need for concurrent treatment of substance use disorders, PTSD, mood disorders and other psychiatric disorders. Interns will use assessment tools such as the Beck Depression Inventory; Beck Anxiety Inventory; the Life Events Check list, and the PCL and Clinician-Administered PTSD Scale.

Supporting Literature

The majority of our nation's Veterans are from rural areas, where patients may have to drive long distances to meet with a mental health provider. In the VA, telemental health (TMH) is an increasingly common mode of treatment delivery, and has been shown to be an effective mode of delivery treatment (Shore et al., 2012). Studies to date are promising, and have shown no significant differences in patients' perceptions of the therapeutic alliance, post-session mood, or overall satisfaction with services when telemental health and face-to-face modalities are compared (Morgan, Patrick, Amber and Magaletta, 2008). Additionally, providing evidenced-based therapy via telemental health to combat Veterans in a rural setting has been shown to be practicable and to produce outcomes that are as good as in-person delivery of the same treatment (Morland, Greene, Rosen, Foy, Reilly, Shore, He, and Frueh, 2010).

Supervisor's Training and Experience

Dr. Ann Smith received her doctorate at Fielding Graduate University and completed her doctoral internship at Columbia Presbyterian Medical Center in Manhattan, where she fulfilled a year-long rotation in Dialectical Behavior Therapy (DBT). As part of her ongoing training as a psychologist, she has trained in Prolonged Exposure Therapy (through the VA's PE Initiative), Mindfulness-based Cognitive Therapy, and Motivational Interviewing. Additionally, she incorporates other evidence based therapies into her work with Veterans, such as Cognitive Processing Therapy and Seeking Safety.

Research Training

The Consortium requires that interns actively engage in research that supports their ability to: 1.) identify and clearly describe the disorders and conditions presented by our patients, 2.) select or create reliable and valid outcomes measures that are sensitive to changes in the patient's disorder or condition, and 3.) identify and successfully administer treatments to improve these disorders or conditions.

To fulfill the core research competency requirement, it is expected that each intern complete a research project during the course of the training year. Supervisors for research activities include VA and UMB staff, including psychologists, psychiatrists, pharmacologists, and health economists. At the beginning of the year, each intern is matched with a research mentor with whom they will develop a research idea, plan a research project, and carry out the research. There is considerable flexibility in the content, scope, and focus of intern projects, however, it is expected that it will consist of a project independent of the dissertation. Up to six hours per week can be used by interns as research time. Toward the end of the year, each intern presents the results of their research in a forum of their fellow peers and faculty. Many interns choose to participate in a poster presentation at the University of Maryland research colloquium, during which time they may present the results of their internship research or dissertation project. Many intern research projects have led to presentations at local, regional, and national

research meetings as well as publications and ongoing collaborations. The research core competency requirement is coordinated by Moira Dux, Ph.D. and Jill Bohnenkamp, Ph.D.

Didactic Opportunities

Consortium Interns meet weekly for two and half hours of required didactic training through a comprehensive Consortium Seminar Series. The seminar series, coordinated by Dr. Clare Gibson, is intended to expose interns to a wide range of clinical and research topics and to stimulate discussion and professional development. Topics include legal and ethical issues, assessment and treatment of various psychological disorders in children and adults, cultural competence, stigma, couples, family and group treatment modalities, as well as career development issues (*e.g.*, post-doctoral fellowships, job talks, licensure, research funding). Presenters are faculty and staff from the University of Maryland, the VA, and guest speakers from local universities and community organizations (such as the National Alliance for the Mentally Ill and the American Psychological Association). A sample schedule is provided in Table 5: 2015-2016 Seminar Schedule (July-November).

Diversity Seminar Series

Embedded within the seminar series is a monthly diversity seminar, coordinated by Dr. Erika White, which is focused on topics that enhance interns' understanding of cultural competence within clinical and research applications. Topics are a blend of didactic material and experiential exercises, designed to enhance intra/interpersonal awareness, knowledge, and practical skills. Topics typically include military culture, disabilities, LGBTQI, race and privilege, spirituality, and microaggressions.

The objectives for the diversity seminar are to:

- provide an atmosphere in which interns and supervisors can explore themselves, their worldviews, and the worldviews of others, and how these beliefs might impact clinical work, scientific research, or professional development
- increase interns' awareness and understanding of cultural factors in diagnostic and therapeutic processes, and the research environment
- broaden interns' effectiveness in counseling and researching persons with diverse characteristics

Additional Didactic Opportunities

In addition to the required weekly seminar series, there are a number of intensive trainings and consultation groups in evidenced-based treatments that are offered to Consortium interns. These include, but are not limited to: Social Skills Training, Cognitive Processing Therapy, Prolonged Exposure, Dialectical Behavior Therapy, Acceptance and Commitment Therapy, and Motivational Interviewing. Most trainings involve a formal workshop that is facilitated by a regional or national trainer, followed by a consultation group to assist in implementation of the treatment modality.

There are many other educational opportunities available at VA and UMB locations including departmental grand rounds, journal clubs, and various symposia. The VA MIRECC organizes a twice-monthly meeting (September through May) at which invited speakers and local researchers present research findings, discuss grants or other projects on which they are working to get input from peers, practice upcoming talks, or discuss other research-related issues. The UMB Division of Services Research journal club meets Fridays at noon to discuss articles on a range of mental health services topics, with special emphasis on methodology issues. There is also a journal club focused on cognitive neuroscience, with emphasis on schizophrenia, which meets at the Maryland Psychiatric

Research Center. The School of Medicine Office of Faculty Affairs and Professional Development offers monthly Psychiatry Grand Rounds and seminars throughout the year on topics such as writing a successful grant application, time management, and teaching methods. The schedule for these activities can be viewed here: http://medschool.umaryland.edu/career/. Last, each specialty track offers a didactics schedule specific to their specialty.

Table 5: 2015-2016 Seminar Schedule (July-November)

Date	Time	Topic	Presenter(s)	Competency Area(s)
7/9/15	9:30-12:00	Introduction to Seminar/ Hopes & Fears	Jade Wolfman-Charles, PhD & Clare Gibson, PhD *VAMHCS Psychologists*	Reflective Practice
7/16/15	9:30-10:45	Introduction to Diversity Seminar & Microaggressions	Erika White, PhD *VAMHCS Psychologist*	Diversity
	11:00-12:00	Military Culture	Jonathan Hollands *VA Peer Support Specialist, Suicide Prevention Team*	Diversity
7/23/15	9:30-12:00	Adult Assessment Seminar	John Sawyer, PhD, *VA Neuropsychologist*	Assessment
7/30/15	9:30-10:30	Boundaries	Clare Gibson, PhD *VAMHCS Psychologist*	Ethics; Intervention
	10:45-12:00	Baltimore Cultural "Bus" Tour	Curtis Adams, MD *Assistant Professor, U of M School of Medicine*	Diversity
8/6/15	9:30-12:00	Cognitive Behavioral Therapy for Insomnia	Sara Clayton, PhD *VAMHCS Psychologist*	Intervention
8/13/15	10:00-11:00	Mandated Abuse Reporting (Note, seminar starts at **10** not 9:30)	Tia Blue *Program Manager at Baltimore City Child Protective Services*	Ethics
	11:00-12:00	Assessment, Treatment & Management of Individuals with a Sexual Offense History	Jim Fleming, PhD *Psychology Services Chief at Patuxent Institution*	Intervention; Assessment
8/20/15	9:30-12:00	Diversity Seminar: Theory and Practice of Person Centered Mental Health Care: Improving Outcomes and Reducing Disparities	Samantha Hack, Ph.D., LGSW *Research Fellow, MIRECC*	Diversity

Date	Time	Topic	Presenter(s)	Competency Area(s)
8/27/15	9:30-10:45	Suicide Risk Assessment	Aaron Jacoby, PhD *VAMHCS Chief Psychologist*	Ethics; Assessment; Intervention
	11:00-12:00	Suicide Intervention	Danielle Jahn, PhD *Assistant Professor, U of M School of Medicine*	Ethics; Intervention
9/3/15	9:30-10:45	Family-centered medication treatment of youth with mental illness	Susan dosReis, PhD *Associate Professor, University of Maryland School of Pharmacy* Gloria Reeves, MD *Associate Professor, University of Maryland School of Medicine*	Research; Intervention; Assessment
	11:00-12:00	Working with Military Families Multidisciplinary Panel	TBA	Intervention
9/10/15	9:30-12:00	Problem Solving Therapy	Ann Aspnes, PhD *VAMHCS Psychologist*	Intervention
9/17/15	9:30-12:00	Diversity Seminar: Step Into the Circle	Viara Quinones, Ph.D. *DC VAMC Psychologist*	Diversity
9/24/15	9:30-10:45	Self-Care	Leigh Ann Carter, PsyD *Towson University*	Ethics
	11:00-12:00	Military Families Topic	TBA	Intervention
10/1/15	9:30-10:45	Family Trauma Treatment	Laurel Kiser, PhD *Associate Professor, Department of Psychiatry University of Maryland School of Medicine*	Intervention; Assessment

Date	Time	Topic	Presenter(s)	Competency Area(s)
	11:00-12:00	Cognitive Behavioral Treatment for Trauma in Schools	Sharon Stephan, PhD *Associate Professor, Division of Child and Adolescent Psychiatry, University of Maryland School of Medicine*	Intervention; Assessment
10/8/15	9:30-10:45	The Fundamentals of Giving Feedback	Jade Wolfman-Charles, PhD *Director, VAMHCS/UM Psychology Internship*	Supervision; Consultation; Professional Conduct
	11:00-12:00	Positive Psychology	Arthur Sandt, PhD *VAMHCS Psychologist*	Intervention
10/15/15	9:30-12:00	Diversity Seminar	TBA	Diversity
10/22/15	9:30-12:00	Peer Support	Jason Peer, PhD, *VAMHCS Local Recovery Coordinator*	Intervention; Consultation
10/29/15	9:30-12:00	Virtual Voices	Cindy Clark, *RN* *VISN 5 MIRECC*	Reflective Practice; Diversity
11/5/15	9:30-12:00	Postdoc panel	TBA	Consultation
11/12/15	9:30-10:45	Intern Clinical Presentations	Interns and Clinical Supervisors	Intervention; Consultation

Assessment Requirement

Consortium interns are required to complete a minimum of six psychological assessments during the training year. Although the nature of the report will vary depending on the clinic, population, and referral question, reports must include the following components to be considered "comprehensive":

1. Review of available pertinent medical records.
2. Development/administration/scoring of an appropriate assessment battery. This may include one of the following:
    a. A multi-scale measure of psychopathology (e.g., MMPI-2-RF)
    b. A multiple performance-based measure of academic achievement, IQ, or neurocognitive functioning (e.g., WJ-IV, WAIS, WISC, RBANS, etc.).
    c. A battery of at least two performance-based neurocognitive measures that your supervisor deems appropriate for the referral question.
    d. A developmental battery (e.g., Bayley Scales, ADOS)
    e. A standardized interval behavioral observation in a naturalized setting (e.g., classroom)
3. Completion of an appropriately thorough diagnostic interview
4. Behavioral Observations
5. Integrative summary of data
6. Diagnostic Impressions
7. Treatment Recommendations
8. Feedback Session

Not required, but encouraged include the administration of self-report inventories, a pre-assessment consultation with the referral source to refine the referral question, and a post-assessment feedback consultation with the referral source to discuss findings/recommendations. Intern assessment proficiency is monitored and evaluated by supervisors and the Assessment Coordinators.

HOW TO APPLY

Applicant Eligibility

1. The VAMHCS/UM SOM Psychology Internship Consortium participates in the APPIC National Matching Service (NMS). Applicants must be registered with NMS and apply through the online APPIC portal. Applicants may register with NMS on the following website: **www.natmatch.com/psychint.** Applicants who do not obtain a position through Phase I of the Match (e.g., applicants who withdraw or remain unmatched in Phase I) will be eligible to participate in Phase II of the Match with our site if those applicants register for the Match prior to the Rank Order List deadline for Phase I.
2. Applicants must be trainees in good standing in an APA-accredited doctoral program in clinical, counseling or school psychology and approved for internship by their graduate program Training Director.
3. Applications will only be reviewed for trainees who have successfully proposed their dissertation prior to the application deadline.
4. Applications will only be reviewed for trainees who have completed more than a total of 500 combined intervention and assessment hours. At least 50 of the total hours must be assessment hours. Hours completed at the Masters and Doctoral level will count toward this requirement. Please keep in mind that the minimum number of intervention and assessment hours provided for our program in the APPIC online directory are set low to accommodate the different priorities of the various Consortium training tracks. For example, an applicant with 200 intervention hours might be competitive for the neuropsychology track, but would likely not be competitive for the more intervention-intensive tracks. Similarly, an applicant with 50 assessment hours would not be competitive for the neuropsychology track, but might be competitive for another track.

5. Interns in VA-based tracks must be citizens of the United States and will have to present documentation of U.S. Citizenship prior to beginning the internship. VA is unable to consider applications from anyone who is not currently a U.S. citizen. Verification of citizenship is required following selection. All interns and fellows must complete a Certification of Citizenship in the United States prior to beginning VA training. A male applicant born after 12/31/1959 must have registered for the draft by age 26 to be eligible for any US government employment, including selection as a paid VA trainee. Male applicants must sign a pre-appointment Certification Statement for Selective Service Registration before they can be processed into a training program. Exceptions can only be granted by the US Office of Personnel Management.
6. Interns and Fellows are subject to fingerprinting and background checks. Selection decisions are contingent on passing these screens.
7. The VA conducts drug screening on randomly selected personnel. Interns are not required to be tested prior to beginning work, but once on staff they are subject to random selection.

Application Procedures

1. Complete the online APPIC APPI
2. In the cover letter, applicants should clearly indicate the track for which they wish to be considered. Indicate that appropriate APPIC Program Codes for each track (see below). Please think carefully about your choices and do not rank tracks that you do not have a serious interest in completing. It is perfectly acceptable to rank only one track if there is only one in which you are interested.
    - VA Comprehensive, Neuropsychology, and Health Psychology Tracks: Please indicate in your cover letter only one track that you wish to be considered for.
    - VA SMI and/or UM SMI Tracks: You may be considered for both tracks if you wish. Please clearly state in your cover letter which track is your top preference**.** You may not be considered for all tracks that you rank. Please note, applicants may not be considered for multiple tracks outside of VA SMI/UM SMI tracks (for e.g., application to VA SMI and VA Comprehensive tracks will not be allowed this year).
    - VA Trauma Recovery and/or UM Trauma Recovery Tracks: You may be considered for both tracks if you wish. Please clearly state in your cover letter which track is your top preference**.** You may not be considered for all tracks that you rank. Please note, applicants may not be considered for multiple tracks outside of VA Trauma Recovery/UM Trauma Recovery tracks (for e.g., application to VA Trauma and VA Comprehensive tracks will not be allowed this year).
    - UM Child Psychology Tracks: You may be considered for up to two out of three child-focused tracks if you wish. Please clearly state in your cover letter which track is your top preference. You may not be considered for all tracks that you rank. Please note, applicants will not be considered for multiple tracks outside of child-focused tracks (for e.g., application to SMHP and adult tracks will not be allowed this year).
3. Submit the required supplemental work sample (i.e., assessment report). Please remove the client's name and any other identifying information. Unless information would identify the client to a likely application reviewer, it is helpful if relevant demographic information and the name of the clinic are included.
4. Do not submit more than three letters of recommendation for our program.
5. All applications materials should be submitted through the on-line APPIC portal: www.appic.org
6. The deadline for submission of applications is November 1, 2015.

Contact Information

Requests for additional information about the VAMHCS/UMB Psychology Internship Consortium may be obtained via email (preferred) or telephone from the following individuals:

Primary Contact:
Jade Wolfman-Charles, Ph.D.
Psychology Training Program Director/Supervisory Psychologist
410-605-7000, ext. 6082
Jade.Wolfman-Charles@va.gov

Secondary Contacts:
Jason Peer, Ph.D.
Associate Director of Training (VA)
410-637-1293
Jason.Peer@va.gov

Nancy Lever, Ph.D.
Associate Director of Training (UM)
410-706-0980
Nlever@psych.umaryland.edu

We request that you do not contact the Consortium with requests to be put into contact with current interns. We will provide opportunity for applicants to speak with current interns once you are selected for an interview.

Selection Procedures

A separate committee of internship training staff from each track reviews and evaluates each application on the domains of clinical experience, research experience, letters of recommendation, quality of graduate program, coursework and grades, life experiences, and goodness of fit with the training program. Each committee decides which applicants will be invited for interviews. Decisions regarding interviews will be communicated via email on or before December 15, 2015. Interviews will be conducted in January 2016. Each applicant meets with up to three supervisors from the track(s) in which they indicated interest. Applicants also have the opportunity to meet with current Consortium interns.

The VAMHCS/UM SOM Psychology Internship Consortium abides by the policies stated in the Association of Psychology Post-Doctoral and Internship Centers (APPIC) Match Policies. This internship site agrees to abide by the APPIC policy that no person at this training facility will solicit, accept, or use any ranking-related information from any intern applicant. Applicants are referred to the APPIC website for a detailed description of policies pertaining to the match: www.appic.org.

The VAMHCS and UM are Equal Opportunity Employers. Our Consortium values cultural and individual diversity and welcomes applicants from all backgrounds.

APPIC Program Codes

Although our consortium is a unified and integrated internship, the training tracks listed below are treated as separate programs by the APPIC matching process.

Track	APPIC Number	# of Positions
VA Comprehensive	134711	2
UM Serious Mental Illness	134712	1
VA Health	134713	2
UM Child Outpatient	134715	1
UM School Mental Health	134716	3
VA Neuropsychology	134717	2
VA Serious Mental Illness	134718	2
VA Trauma Recovery	134719	2
UM Trauma Recovery	134721	1

CONSORTIUM ADMINISTRATION AND STAFF

Consortium Steering Committee

This committee has the authority and responsibility to ensure the quality of all aspects of the Consortium training program. The members of the committee are:

Jade Wolfman-Charles, Ph.D. Psychology Training Program Director, VAMHCS/UM SOM Psychology Internship Consortium
University of Maryland, Baltimore County, 2009, Human Services Psychology
Psychology Training Program Director, VAMHCS/UM SOM Psychology Internship Consortium
VAMHCS Supervisory Psychologist
VA National Motivational Interviewing/Motivational Enhancement Therapy Consultant
Licensed Psychologist in Maryland.
Interests: Evidence-based and culturally sensitive practices in the treatment of addictive disorders; Motivational interviewing; Transtheoretical Model of Change

Melanie Bennett, Ph.D.	Professor of Psychiatry and Director of the Division of Psychology, University of Maryland School of Medicine Rutgers University, 1995. Clinical Psychology. Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine. Licensed Psychologist in Maryland. Interests: Etiology and treatment of substance use disorders and serious mental illness, screening for substance use disorders, prevention of substance use disorders
Aaron Jacoby, Ph.D.	Chief Psychologist, VAMHCS Catholic University of America, 2004, Clinical Psychology Chief Psychologist, VAMHCS. Licensed Psychologist in Pennsylvania Interests: Evidence-based psychotherapies for PTSD including prolonged exposure therapy and cognitive processing therapy; PTSD assessment; patient satisfaction; Program development.
Joseph Liberto, M.D.	Associate Chief of Staff for Education and Academic Affiliations, VAMHCS University of Maryland, 1986. Psychiatry. Associate Chief of Staff for Education & Academic Affairs Interests: Pharmacological treatment of addictions, health care services for addictions.
Sarah Reading, M.D.	Director, VAMHCS Mental Health Clinical Center University of South Florida, College of Medicine, 1996. Psychiatry. Director, Mental Health Clinical Center Interests: Improving the quality of mental health care for patients, reducing stigma for patients and their families.

Consortium Training Committee

This committee is responsible for the day-to-day operation of the internship and for maintaining the Consortium's compliance with the criteria for accreditation of the American Psychological Association (APA) and with the guidelines of the Association of Psychology Postdoctoral and Internship Centers (APPIC). The Training Director and Training Committee closely oversee the recruitment process and the selection process to assure equitable treatment of all applicants and adherence to the standards of both APPIC and APA. The Committee is responsible for coordinating material and human resources, selection of interns, evaluating facilities for continued participation in the Consortium, the content of the Core Curriculum Seminars, and ensuring the quality of the clinical supervision within the internship.

Associate Director of Training, UMB - Nancy Lever, Ph.D.:

In addition to sharing the responsibilities of the Training Committee, this individual is responsible for coordinating interns and training staff assigned to UM clinics, including communicating with administrative staff regarding hiring, orientation, and payroll. This individual is available to address any concerns raised by interns or training staff at UM sites.

Associate Director of Training, VAMHCS- Jason Peer, Ph.D.:

Similar to the Associate Director of Training role described above, this individual assists with issues that arise among VA-based interns and staff, with special attention to internship activities at the Perry Point VAMC, since the Training Director is typically based in Baltimore.

Assessment Co-Coordinators- John Sawyer, Ph.D. and Rebecca Vivrette, Ph.D.:

The Assessment Coordinators are responsible for coordinating the interns' training activities in the area of psychological assessment. These individuals ensure that interns are informed of the year-long assessment requirement and the criteria for assessments, track the completion of assessments throughout the year, works with supervisors and staff to optimize assessment opportunities, and provide supervision on assessment-related topics.

Seminar Coordinator- Clare Gibson, Ph.D.:

The Seminar Coordinator is responsible for developing core educational activities for interns, both across and within sites. The Coordinator collaborates with the Training Director and Training Committee in regards to the content of the seminars and relationship between the content of the core curriculum and training objectives. The Coordinator is responsible for the selection and scheduling of consultants, faculty seminars, and guest speakers.

Cultural Competence Coordinator- Erika White, Ph.D.:

The Cultural Competence Coordinator contributes to the Consortium's overall mission of excellence in training in issues of diversity. The Coordinator is responsible for retention of interns dedicated to training in cultural competence, implementing a curriculum that provides training in all areas of diversity, and serving as a mentor and supervisor to interns that participate in the Diversity Minor training experience. Finally, this individual may represent the Consortium at local and national conferences dedicated to diversity and cultural competence for recruitment of interns.

Research Co-Coordinators- Moira Dux, Ph.D. and Jill Bohnenkamp, Ph.D.:

The Research Coordinators contribute to the Consortium's overall mission by creating a scientist-practitioner environment for interns. The Coordinators are responsible for establishing research opportunities that have relevance to clinical practice across the VAMHCS and UMB, guiding and mentoring interns in their research involvements, and evaluating interns' progress.

Intern Representative(s):

One or more intern volunteers are identified at the beginning of the training year to serve as representative(s) to the Training Committee. They provide invaluable input from the interns' perspective into the Training Committee's discussions and decisions and serve as a conduit for any concerns that the interns may want to bring to the Training Committee.

Clinical and Training Staff – VAMHCS

MELISSA D. BARONE, PSY.D
La Salle University, 2007. Clinical Psychology
Director of Postdoctoral Fellowship in PTSD in Returning Veterans
Licensed Psychologist in Maryland
Interests: Dissemination of empirically supported treatments for PTSD, research and treatment on comorbid PTSD and medical disorders

ANN BRUGH, PH.D
Spalding University, 2011. Clinical Psychology.
Staff Psychologist, VAMHCS Primary Care Clinic
Licensed Psychologist in Maryland
Interests: Chronic pain, diabetes management, and implementation of integrated healthcare

DAVID O'CONNOR, PH.D
Florida State University, 2002. Clinical Psychology
Staff psychologist
Licensed Psychologist in Maryland
Interests: Addictions, stages of change

JASON PEER, PH.D
University of Nebraska-Lincoln, 2006. Clinical Psychology.
Staff Psychologist; Local Recovery Coordinator.
Associate Director, VAMHCS/UM SOM Psychology Internship Consortium Training Committee
Licensed Psychologist in Maryland.
Interests: serious mental illness, psychosocial treatment response, vocational functioning in SMI, program

evaluation.

ERIN BURNS, PH.D
University of Georgia, 2012. Clinical Psychology
Staff Psychologist, Trauma Recovery Program
Licensed Psychologist in Maryland
Interests: Treatment of moral injury and the use of stage-based approach for PTSD treatment

CHRISTINE CALMES, PH.D.
University at Buffalo: The State University of New York, 2008, Clinical Psychology
Staff psychologist, Trauma Recovery Program
Licensed Psychologist in Maryland
Interests: Helping individuals with serious mental illness to manage their medical and psychiatric symptoms in order to reach their recovery goals

SARA CLAYTON, PH.D.
University of Wyoming, 2009. Clinical Psychology
Staff Psychologist, VAMHCS Chronic Pain Service/University of Maryland Adolescent and Young Adult Center HIV Clinic
Licensed Psychologist in Maryland.
Interests: Behavioral treatments for HIV and chronic pain

GARNETTE COTTON, PH.D.
University of Georgia, 2003, Clinical Psychology
Staff Psychologist, VAMHCS Telemental Health Program
Licensed Psychologist in Maryland
Interests: use of alcohol and substances in ethnic minority populations, culturally competent treatment provision of evidence based treatment modalities.

MOIRA DUX, PH.D
Rosalind Franklin University of Medicine and Science, 2009, Neuropsychology
Research Coordinator, VAMHCS/UM SOM Psychology Internship Consortium Training Committee
Staff Neuropsychologist, VAMHCS
Interests: Mechanisms of cognition and affect in healthy elderly, effects of highly active antiretroviral therapy (HAART) on cognition in persons who are HIV+, and intraindividual variability in cognitive test performance.

JODI FRENCH, PSY.D

MICHAEL POET, PSY.D
La Salle University, 2008. Clinical Psychology
MHCC Coordinator, Perry Point
Licensed Psychologist in Maryland
Interests: Administrative psychology, implementation of evidence-based practices for general mental health

EILEEN POTOCKI, PH.D.
Florida State University, Clinical Psychology
Staff Psychologist, Primary Care Mental Health Integration
Licensed Psychologist in Maryland
Interests: Underserved populations

PATRICIA RYAN, PH.D.
Fordham University, 2006, Counseling Psychology
Neuropsychologist, VAMHCS
Licensed Psychologist in Maryland
Interests: Neuropsychological assessment and cognitive rehabilitation for traumatic and acquired brain injury; post-stroke depression; adjustment and coping with physical and cognitive disabilities.

JULIE RIFE-FREESE, PH.D
Argosy University, 2007, Clinical Psychology
Licensed psychologist in Maryland
Interests: Recovery oriented treatment of individuals with a Serious Mental Illness

ERIN ROMERO, PH.D.
Northwestern University Feinberg School of Medicine, 2009, Clinical Psychology
Supervisory Psychologist, Trauma Recovery Program Coordinator
Interests: Barriers to mental health treatment; Virtual reality treatment for PTSD

ANDREW SANTANELLO, PSY.D.

Virginia Consortium in Clinical Psychology, 1991.
Neuropsychologist, Community Living Center.
Licensed Psychologist in Maryland and Virginia.
Interests: Capacity Assessments, Behavioral Interventions for Challenging Behaviors in Long-Term Care; Use of Embedded Symptom Validity Tests, Cognitive-Behavioral Interventions for Mood and Anxiety Disorders; Caregiver Support and Bereavement Counseling.

JAMES FINKELSTEIN, PSY.D.
Loyola College in Maryland, 2003. Clinical Psychology
Staff Psychologist, Acceptance and Commitment Therapy Program
Licensed Psychologist in Maryland
Interests: Substance use disorders, mindfulness-based interventions

CLARE GIBSON, PH.D
University of North Carolina at Chapel Hill, 2012 Clinical Psychology
Seminar Coordinator, VAMHCS/UM SOM Psychology Internship Consortium Training Committee
Staff Psychologist, Baltimore Psychosocial Rehabilitation and Recovery Center
Licensed Psychologist in Maryland
Interests: Psychosocial treatments for SMI and factors related to recovery, self-stigma, self-care for mental health professionals

ANJELI INSCORE, PH.D.
Loyola College, 2002. Clinical Psychology
Licensed Psychologist in Maryland
Interests: Assessment of conditions associated with dementia and the effects of metabolic dysfunction on neurocognition

ELYSE KAPLAN, PSY.D
Loyola University, Maryland
Health Behavior Coordinator
Clinical Health Psychologist
Licensed Psychologist in Maryland
Interests: Chronic disease management (Diabetes, HIV); primary care-mental health integration, health behavior change, pre-surgical evaluations.

MIRANDA KOFELDT, PH.D
University of Maryland-Baltimore County, 2011 Clinical Psychology
Staff Psychologist, Adult Outpatient Psychiatry Clinic
La Salle University, 2006, Clinical Psychology
Psychologist, Trauma Recovery Program
CPT Regional Trainer
Licensed psychologist in Maryland
Interests: Promotion and dissemination of evidence-based psychotherapy and mindfulness-based psychological treatments

ARTHUR SANDT, PH.D
Temple University, 2011, Clinical Psychology
Psychologist, General Outpatient Substance Abuse Program
Licensed psychologist in Maryland
Interests: Acceptance and Commitment Therapy, Emotion, Motivation, and Psychophysiology

JOHN R. SAWYER, PH.D
University of Memphis, 2012, Counseling Psychology
Neuropsychologist, Neuropsychology Program
Assessment Coordinator, VAMHCS/UM SOM Psychology Internship Consortium Training Committee
Licensed psychologist in Maryland
Interests: geriatrics, stroke, TBI, and learning disabilities, program development and cognitive rehabilitation

MELISSA SCHNEIDER, PSY.D
La Salle University, 2010. Clinical Psychology
Staff Psychologist, Medical Psychology
Licensed Psychologist in Pennsylvania
Interests: Chronic medical illnesses (diabetes; HIV; Hepatitis C); pre-surgical evaluations; chronic pain; health behavior change; primary care-mental health integration

JOSHUA SEMIATIN, PH.D
University of Maryland-Baltimore County, 2012 Clinical Psychology
Psychologist, Trauma Recovery Program
RRTP Team Leader
Licensed psychologist in Maryland
Interests: Impacts of trauma and PTSD on anger and aggression, particularly intimate partner violence (IPV) and childhood physical abuse

ANN SMITH, PSY.D
Fielding University, 2006. Clinical Psychology
Psychologist, VAMHCS Cambridge Outpatient Clinic
Licensed Psychologist in Maryland
Interests: Evidenced based treatments for PTSD/SUD

Licensed Psychologist in Maryland
Interests: Transtheoretical Model of Behavior Change, motivational interviewing and motivational enhancement techniques, trauma-informed approaches to treatment, and cognitive behavioral therapies

SAM KOROBKIN, PH.D.
St. John's University, 2000. Clinical Psychology
Staff Psychologist, Family Intervention Team
Evidence Based Psychotherapy Coordinator
Licensed Psychologist in Maryland and California
Interests: Recovery from serious mental illness, health psychology, and couples/individual psychotherapy

MARY GARDNER, PH.D.
University of Maryland, 2002. Clinical Psychology
Coordinator, Perry Point PRRC and Recovery Center
Licensed Psychologist in Maryland
Interests: Serious mental illness, mindfulness-based approaches to psychotherapy

TERRY LEE-WILK, PH.D.
University of Maryland, 2002. Clinical Psychology
Neuropsychologist
Licensed Psychologist in Maryland
Neurocognitive correlates of Multiple Sclerosis, HIV infection, and mild traumatic brain injury

KRISTEN MORDECAI, PH.D.
Rosalind Franklin University of Medicine and Science, 2007, Clinical Psychology (neuropsychology)
Staff Neuropsychologist, VAMHCS
Licensed psychologist in Maryland
Interests: Cognitive aging, dementia, Parkinson's disease, stress and memory, and the effects of sex steroid hormones on cognition and brain function

and other co-occurring disorders, telemental health, rural mental health

NEIL WEISSMAN, PSY.D.
Yeshiva University, 1990. Clinical Psychology.
Staff psychologist, Psychosocial Rehabilitation and Recovery Center
Licensed Psychologist in Maryland.
Interests: The Recovery Model for individuals with SMI. Emotionally Focused Couples Therapy (EFT) for couples with PTSD

ERIKA WHITE, PH.D
St. Louis University, 2011, Clinical Psychology
Psychologist/Team Lead PTSD Clinical Team
Cultural Competence Coordinator, VAMHCS/UM SOM Psychology Internship Consortium Training Committee
Interests: Microaggressions and colorblindness on the working alliance of cross-racial counseling dyads

SARA NETT, PSY.D.
Indiana State University, 2008, Clinical Psychology
Staff Psychologist, Trauma Recovery Program
Military Sexual Trauma Coordinator
Licensed Psychologist in Maryland
Interests: Recovery from posttraumatic stress disorder; Treating Veterans with comorbid personality disorders and history of complex trauma

MARK NOLDER, PH.D
Texas Tech University, 1990, Counseling Psychology
Staff Psychologist, Fort Howard Community Based Outpatient Clinic
Licensed Psychologist in Maryland
Interests: Psychoanalytic metapsychology, evidence-based psychoanalytic psychotherapy, evidence based psychotherapy relationship factors, psychotherapy supervision, psychology of music, individual psychoanalytic psychotherapy

Clinical and Training Staff- MIRECC

JENNIFER AAKRE, PH.D
Kent State University, 2008. Clinical Psychology
Administrative Core Manager, VISN 5 MIRECC
Licensed Psychologist in Maryland
Interests: Comorbidity of PTSD and Serious Mental Illness

AMY DRAPALSKI, PH.D
George Mason University, 2006. Clinical Psychology
Associate Director, Clinical Core, VISN 5 MIRECC
Clinical Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine.
Licensed Psychologist in Maryland
Interests: Serious mental illness and recovery, stigma and other barriers to mental health care, family services

MELANIE BENNETT, PH.D.
Rutgers University, 1995. Clinical Psychology
Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine
Licensed Psychologist in Maryland
Interests: Etiology and treatment of substance use disorders and serious mental illness, screening for substance use disorders, prevention of substance use disorders

RICHARD GOLDBERG, PH.D.
University of Maryland-College Park, 1994
Clinical/Community Psychology
Associate Professor, Division of Services Research, Department of Psychiatry
Director, Clinical Core VISN 5 MIRECC
Co-Director, Hub Site for the VA Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery
Licensed Psychologist in Maryland
Interests: Mental health services research, somatic comorbidity, behavioral health and wellness interventions, SMI/public sector psychiatry, group psychology, research and clinical supervision

Clinical and Training Staff- UMB

LAURA ANDERSON, PH.D.
University of Denver, 2005
Clinical Research Specialist, University of Maryland, Baltimore Systems Evaluation Center
Licensed Psychologist in Maryland
Interests: trauma, dialectical behavior therapy, mindfulness, therapeutic alliance, supervision and training

MICHAEL GREEN, M.S.W., L.C.S.W.-C.
University of Maryland School of Social Work-Baltimore, Maryland, 2003. Social Work
Associate Director, University of Maryland School Mental Health Program
Clinician, Franklin Square Elementary/Middle School
Interests: School mental health, student leadership, meaningful activity involvement, resiliency, family engagement and collaboration, and evidence-based practice in schools

VICKI BECK, A.P.R.N., B.C.
Texas Women's University, 1975
Board Certified Child and Adolescent Clinical Nurse Specialist
Administrative Director, Child Psychiatry Outpatient Clinic
Interests: Children and adolescents, aggression management, evidence-based practice in outpatient settings, trauma

LAUREL KISER, PH.D., M.B.A.
Indiana University, 1981. School Psychology
Associate Professor, Center for Mental Health Services Research, Department of Psychiatry, University of Maryland School of Medicine
Principal Investigator, Children's Outcome Monitoring Center
Interests: Children and adolescents, services research, family ritual and routine, chronic illness, PTSD

KIMBERLY BECKER, PH.D.
University of Hawaii, Clinical Psychology
Assistant Professor, University of Maryland Department of Psychiatry

MIRANDA KOFELDT, PH.D.
University of Maryland Baltimore County, 2011
Human Services Psychology/Behavioral Medicine
Adult Psychologist 2nd Floor University of Maryland

Interests: Improving the effectiveness of evidence-based prevention and treatment interventions for children and adolescents through innovations in provider training and clinical decision-making

MELANIE BENNETT, PH.D.
Rutgers University, 1995. Clinical Psychology
Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine
Licensed Psychologist in Maryland
Interests: Etiology and treatment of substance use disorders and serious mental illness, screening for substance use disorders, prevention of substance use disorders

JILL BOHNENKAMP, PH.D.
University of Virginia, 2012, Clinical and School Psychology
Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine
Interests: School mental health, behavioral and academic outcomes of service provision, promoting positive social and emotional development through teacher and parent training, evidence-based practice, workforce development, and increasing children's access to mental health services

ELIZABETH CONNORS, PH.D.
University of Maryland Baltimore County, 2014
Child Clinical/Community Psychology
Research Associate, Department of Psychiatry, University of Maryland School of Medicine
Interests: Quality and evidence-based practice in school mental health, including dissemination and implementation methods, workforce development and comprehensive program evaluation

KAY CONNORS, L.C.S.W.
New York University, 1985
Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine
Program Director, Taghi Modarressi Center for Infant Study, Department of Psychiatry
Interests: Early childhood mental health services, trauma treatment, family, parent-child and group

Medical Center Adult Outpatient Psychiatry Clinic
Licensed Psychologist in Maryland
Interests: motivational interviewing and the Transtheoretical Model of Behavior Change, treatment of substance abuse, trauma informed care, CBT/DBT, supervision/training

NANCY LEVER, PH.D.
Temple University, 1997. Clinical Psychology.
Associate Director VAMHCS/UM SOM Psychology Internship Consortium
Director of Training and Outreach, Center for School Mental Health
Director, University of Maryland School Mental Health Program
Associate Professor, Department of Psychiatry, University of Maryland School of Medicine
Licensed Psychologist in Maryland
Interests: School based mental health services, dropout prevention, quality assessment and improvement, evidence-based practice in schools, resiliency, resource development

DEBORAH MEDOFF, PH.D.
University of Maryland College Park, 1989, Quantitative Psychology
Assistant Professor, Department of Psychiatry, Division of Services Research
Professional interests include developing research designs to minimize consent bias, analytic techniques for missing data in longitudinal research and the trajectories of recovery for persons with serious mental illness

TOM SLOANE, M.S., L.C.P.C.
Loyola College, Baltimore, Maryland, 1984
Counseling Psychology
Program Manager, Baltimore School Mental Health Initiative
Interests: School mental health, promoting resilience in youth, graduate externship training, and adolescent mental health

SHARON STEPHAN, PH.D.
University of Maryland Baltimore County, 2002
Clinical Psychology
Co-Director, Center for School Mental Health, University of Maryland School of Medicine
Associate ProfessorLicensed Psychologist in Maryland.
Interests: School Mental Health, Evidence-based practice in school mental health, trauma and youth

therapies and clinical supervision

JEN COX, L.C.S.W-C.
University of Maryland School of Social Work, Baltimore, MD, 2006
Associate Director of the University of Maryland School Mental Health Program (SMHP)
Interests: Promoting resilience in youth, family engagement and partnership, and developing effective funding models

DANA CUNNINGHAM, PH.D.
Southern Illinois University-Carbondale, 2004. Clinical Psychology
Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine
Coordinator, Prince's George's County School Mental Health Initiative
Licensed Psychologist in Maryland.
Interests: School-based mental health, resilience, community building, special education

ELEANOR DAVIS, M.S.W., L.C.S.W.-C.
University of Maryland School of Social Work-Baltimore, Maryland, 1995 Social Work
Managing Director, Center for School Mental Health/University of Maryland School Mental Health Program
Interests: School mental health, cost effectiveness, business management of mental health programs, staff development

RICHARD GOLDBERG, PH.D.
University of Maryland-College Park, 1994
Clinical/Community Psychology
Associate Professor, Division of Services Research, Department of Psychiatry
Director, Clinical Core VISN 5 MIRECC
Co-Director, Hub Site for the VA Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery
Licensed Psychologist in Maryland
Interests: Mental health services research, somatic comorbidity, behavioral health and wellness interventions, SMI/public sector psychiatry, group psychology, research and clinical supervision

REBECCA VIVRETTE, PH.D.
California School of Professional Psychology, 2014. Clinical Psychology
Postdoctoral Fellow, University of Maryland Division of Child and Adolescent Psychiatry
Interests: Early childhood mental health, assessment, impact of maternal health and mental health on childhood development, child traumatic stress

CATHERINE WEISS, PH.D.
University of Maryland Baltimore County, 2004
Clinical/Community Psychology
Supervisor/Consultant, University of Maryland School Mental Health Program
Instructor, Department of Psychiatry, University of Maryland School of Medicine
Interests: Staff wellness, evidence-based practice in school mental health, professional development for school staff, reducing suspensions and expulsions in schools

KELLY DUNN, L.C.S.W.-C
University of Maryland School of Social Work-Baltimore, Maryland, 2009. Social Work
Assistant Director, University of Maryland School Mental Health Program
Interests: School mental health, gambling prevention, anger management, quality improvement

APPENDIX

APPENDIX A

VAMHCS/UMB PSYCHOLOGY INTERNSHIP CONSORTIUM

PSYCHOLOGY TRAINEE COMPETENCY ASSESSMENT FORM

Trainee:_____ Supervisor: _____ Date: _____

Rotation/Clinic:

Evaluation time point: UM interns: First mid-year (Oct.)
Second mid-year (Feb.)
Final

VA interns:

1st rotation	mid	final
2nd rotation	mid	final
3rd rotation	mid	final

ASSESSMENT METHOD(S)

_____ Direct observation
_____ Videotape
_____ Audiotape
_____ Case presentation
_____ Review of written work
_____ Review of raw test data
_____ Discussion of clinical interaction
_____ Comments from other staff

COMPETENCY RATINGS DESCRIPTIONS

NA **Not applicable for this training experience/Not assessed during training experience**

A **Advanced/Skills comparable to autonomous practice at the licensure level.** This **r**ating is typically expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however as an unlicensed trainee, supervision is required while in training status.

HI **High intermediate/Occasional supervision needed.** This rating is frequently appropriate for trainees at completion of internship. It indicates that competency has been attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant.

I **Intermediate/Should remain a focus of supervision.** This is a common rating throughout internship and pre-internship practica. Routine supervision of each activity is needed.

E **Entry level/Continued intensive supervision is needed.** This is the most common rating for practica-level trainees. Routine, but intensive, supervision is needed.

R **Needs remedial work**. Requires remedial work if trainee is in internship or post-doctoral training.

GOAL: COMPETENCE IN PROFESSIONAL CONDUCT, ETHICS AND LEGAL MATTERS

OBJECTIVE: PROFESSIONAL INTERPERSONAL BEHAVIOR

Interactions with treatment teams, peers and supervisors are professional and appropriate; Trainee seeks peer support as needed.

A Smooth working relationships, handles differences openly, tactfully and effectively.

HI Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns.

I Progressing well on providing input in a team setting. Effectively seeks assistance to cope with interpersonal concerns with colleagues.

E Ability to participate in team model is limited, relates well to peers and supervisors.

R May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

OBJECTIVE: SEEKS CONSULTATION/SUPERVISION

Seeks consultation or supervision as needed and uses it productively.

A Actively seeks consultation when treating complex cases and working with unfamiliar symptoms.

HI Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain; Occasionally over- or under-estimates need for supervision.

I Generally accepts supervision well, but occasionally defensive. Needs supervisory input for determination of readiness to try new skills.

E Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.

R Frequently defensive and inflexible; Resists important and necessary feedback.

OBJECTIVE: USES POSITIVE COPING STRATEGIES

Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.

A Good awareness of personal and professional problems. Stressors have only mild impact on professional practice. Actively seeks supervision and/or personal therapy to resolve issues.

HI Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact.

I Needs significant supervision time to minimize the effect of stressors on professional functioning. Accepts reassurance from supervisor well.

E Personal problems can significantly disrupt professional functioning.

R Denies problems or otherwise does not allow them to be addressed effectively.

OBJECTIVE: PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION

Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.

A Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.

HI Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.

I Uses supervisory feedback well to improve documentation. Needs regular feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.

E Needs considerable direction from supervisor. May leave out crucial information.

R May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

OBJECTIVE: EFFICIENCY AND TIME MANAGEMENT

Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.

A Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.

HI Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner, but needs occasional deadlines or reminders.

I Completes work effectively and promptly by using supervision time for guidance. Regularly needs deadlines or reminders.

E Highly dependent on reminders or deadlines.

R Frequently has difficulty with timeliness fashion. Or tardiness or unaccounted absences are a problem.

OBJECTIVE: KNOWLEDGE OF ETHICS AND LAW

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

A Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgement is reliable about when consultation is needed

HI Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.

I Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.

E Often unaware of important ethical and legal issues.

R Disregards important supervisory input regarding ethics or law.

OBJECTIVE: ADMINISTRATIVE COMPETENCY

Demonstrates a growing ability to accomplish administrative tasks. Prioritizes appropriately. Shows a growing autonomy in management of larger administrative, research or clinical projects.

A Independently assesses the larger task to be accomplished, breaks the task into smaller ones and develops a timetable. Prioritizes various tasks and deadlines efficiently and without need for supervisory input. Makes adjustments to priorities as demands evolve.

HI Identifies components of the larger task and works independently on them. Needs some supervisory guidance to successfully accomplish large tasks within the timeframe allotted. Identifies priorities but needs input to structure some aspects of task.

I Completes work effectively, using supervision time to identify priorities and develop plans to accomplish tasks. Receptive to supervisory input to develop own skills in administration.

E Trainee takes on responsibility then has difficulty asking for guidance or accomplishing goals within timeframe.

R Deadline passes without task being done. Not receptive to supervisory input about own difficulties in this process.

GOAL: COMPETENCE IN INDIVIDUAL AND CULTURAL DIVERSITY

OBJECTIVE: PATIENT RAPPORT

Consistently achieves a good rapport with patients.

A Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.

HI Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.

I Actively developing skills with new populations. Relates well when has prior experience with the population.

E Has difficulty establishing rapport.

R Alienates patients or shows little ability to recognize problems.

OBJECTIVE: SENSITIVITY TO PATIENT DIVERSITY

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

A Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.

HI In supervision, recognizes and openly discusses limits to competence with diverse clients.

I Has significant lack of knowledge regarding some patient groups, but resolves such issues effectively through supervision. Open to feedback regarding limits of competence.

E Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.

R Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

OBJECTIVE: AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND

Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.

A Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.

HI Aware of own cultural background. Uses supervision well to examine this in psychological work. Readily acknowledges own culturally-based assumptions when these are identified in supervision.

I Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differences that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.

E Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and conceptualizations from culturally-based assumptions. Responds well to supervision.

R Has little insight into own cultural beliefs even after supervision.

GOAL: COMPETENCE IN THEORIES AND METHODS OF PSYCHOLOGICAL DIAGNOSIS AND ASSESSMENT

OBJECTIVE: DIAGNOSTIC SKILL

Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclature and DSM multiaxial classification. Utilizes historical, interview and psychometric data to diagnose accurately.

A Demonstrates a thorough knowledge of psychiatric classification, including multiaxial diagnoses and relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.

HI Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good. Uses supervision well in more complicated cases involving multiple or more unusual diagnoses.

I Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May miss relevant patient data when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.

E/R Has significant deficits in understanding of the psychiatric classification system and/or ability to use DSM-5 criteria to develop a diagnostic conceptualization.

OBJECTIVE: PSYCHOLOGICAL TEST SELECTION AND ADMINISTRATION

Promptly and proficiently administers commonly used tests in his/her area of practice. Appropriately chooses the tests to be administered.

N/A Not applicable.
A Proficiently administers all tests. Completes all testing efficiently. Autonomously chooses appropriate tests to answer referral question.
HI Occasional input needed regarding fine points of test administration. Occasionally needs reassurance that selected tests are appropriate.
I Needs continued supervision on frequently administered tests. Needs occasional consultation regarding appropriate tests to administer.
E/R Test administration is irregular, slow, or often needs to recall patient to further testing sessions due to poor choice of tests administered.

OBJECTIVE: PSYCHOLOGICAL TEST INTERPRETATION

Competently interprets the results of psychological tests used in his/her area of practice.

N/A Not applicable
A Skillfully and efficiently interprets tests autonomously. Makes accurate independent diagnostic formulations on a variety of syndromes. Accurately interprets and integrates results prior to supervision session.
HI Demonstrates knowledge of scoring methods, reaches appropriate conclusions with some support from supervision.
I Completes assessments on typical patients with some supervisory input, occasionally uncertain how to handle difficult patients or unusual findings. Understands basic use of tests, may occasionally reach inaccurate conclusions or take computer interpretation packages too literally.
E/R Significant deficits in understanding of psychological testing, over-reliance on computer interpretation packages for interpretation. Repeatedly omits significant issues from assessments, reaches inaccurate or insupportable conclusions.

OBJECTIVE: ASSESSMENT WRITING SKILLS

Writes a well-organized psychological report. Answers the referral question clearly and provides the referral source with specific recommendations.

N/A Not applicable
A Report is clear and thorough, follows a coherent outline, and is an effective summary of major relevant issues. Relevant test results are woven into the report as supportive evidence. Recommendations are related to referral questions.
HI Report covers essential points without serious error, may need polish in cohesiveness and organization. Readily completes assessments with minimal supervisory input, makes useful and relevant recommendations.
I Uses supervision effectively for assistance in determining important points to highlight.
E/R Inaccurate conclusions or grammar interfere with communication or reports are poorly organized and require major rewrites.

OBJECTIVE: FEEDBACK REGARDING ASSESSMENT

Plans and carries out a feedback interview. Explains the test results in terms the patient and/or caregiver can understand, provides suitable recommendations and responds to issues raised by patient or caregiver.

N/A Not applicable

A Plans and implements the feedback session appropriately. Foresees areas of difficulty in the session and responds empathically to patient or caregiver concerns. Adjusts personal style and complexity of language and feedback details to accommodate patient or caregiver needs.

HI With input from supervisor, develops and implements a plan for the feedback session. May need some assistance to identify issues which may become problematic in the feedback session. May need intervention from supervisor to accommodate specific needs of patient or family.

I Develops plan for feedback session with the supervisor. Presents basic assessment results and supervisor addresses more complex issues. Continues to benefit from feedback on strengths and areas for improvement.

E Supervisor frequently needs to assume leadership in feedback sessions to ensure correct feedback is given or to address emotional issues of patient or caregiver.

R Does not modify interpersonal style in response to feedback.

GOAL: COMPETENCE IN THEORIES AND METHODS OF EFFECTIVE PSYCHOTHERAPEUTIC INTERVENTION

OBJECTIVE: PATIENT RISK MANAGEMENT AND CONFIDENTIALITY

Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.

A Assesses and documents all risk situations fully prior to leaving the worksite for the day. Appropriate actions taken to manage patient risk situations (e.g. escorting patient to ER) are initiated immediately, then consultation and confirmation of supervisor is sought. Establishes appropriate short-term crisis plans with patients.

HI Aware of how to cope with safety issues, continues to need occasional reassurance in supervision. Asks for input regarding documentation of risk as needed. Sometimes can initiate appropriate actions to manage patient risk, sometimes needs input of supervisor first. May occasionally forget to discuss confidentiality issues promptly.

I Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards trainee handles them well. Can be trusted to seek consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. Needs input regarding documentation of risk. Occasionally needs prompting to discuss confidentiality issues with patient.

E Delays or forgets to ask about important safety issues. Does not document risk appropriately but does not let patient leave site without seeking "spot" supervision for the crisis. Does not remember to address confidentiality issues, needs frequent prompting. Fear may overwhelm abilities in patient crises.

R Makes inadequate assessment or plan, then lets patient leave site before consulting supervisor.

OBJECTIVE: CASE CONCEPTUALIZATION AND TREATMENT GOALS

Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.

A Independently produces good case conceptualizations within own preferred theoretical orientation, can also draw some insights into case from other orientations. Consistently sets realistic goals with patients.

HI Reaches case conceptualization on own, recognizes improvements when pointed out by supervisor. Readily identifies emotional issues but sometimes needs supervision for clarification. Sets appropriate goals with occasional prompting from supervisor, distinguishes realistic and unrealistic goals.

I Reaches case conceptualization with supervisory assistance. Aware of emotional issues when they are clearly stated by the patient, needs supervision for development of awareness of underlying issues. Requires ongoing supervision to set therapeutic goals aside from those presented by patient.

E/R Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives important emotional issues. Unable to set appropriate treatment goals with patient.

OBJECTIVE: THERAPEUTIC INTERVENTIONS

Interventions are well-timed, effective and consistent with empirically supported treatments.

A Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed.

HI Most interventions and interpretations facilitate patient acceptance and change. Supervisory assistance needed for timing and delivery of more difficult interventions.

I Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.

E/R Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation.

OBJECTIVE: EFFECTIVE USE OF EMOTIONAL REACTIONS IN THERAPY (COUNTERTRANSFERENCE)

Understands and uses own emotional reactions to the patient productively in the treatment.

A During session, uses countertransference to formulate hypotheses about patient's current and historical social interactions, presents appropriate interpretations and interventions. Able to identify own issues that impact the therapeutic process and has ideas for coping with them. Seeks consultation as needed for complex cases.

HI Uses countertransference to formulate hypotheses about the patient during supervision sessions. Can identify own issues that impact therapeutic process. Interventions generally presented in the following session.

I Understands basic concepts of countertransference. Can identify own emotional reactions to patient as countertransference. Supervisory input is frequently needed to process the information gained.

E When feeling anger, frustration or other intense emotional response to the patient, blames patient at times. Welcomes supervisory input and can reframe own emotional response to the session.

R Unable to see countertransference issues, even with supervisory input.

OBJECTIVE: GROUP THERAPY SKILLS AND PREPARATION

Intervenes in group skillfully, attends to member participation, completion of therapeutic assignments, group communication, safety and confidentiality. If the group is psychoeducational, readies materials for group, and understands each session's goals and tasks.

A Elicits participation and cooperation from all members, confronts group problems appropriately and independently, and independently prepares for each session with little or no prompting. Can manage group alone in absence of cotherapist/supervisor with follow-up supervision later.

HI Seeks input on group process issues as needed, then works to apply new knowledge and skills. Needs occasional feedback concerning strengths and weaknesses. Generally prepared for group sessions.

I Welcomes ongoing supervision to identify key issues and initiate group interaction. Actively working on identifying own strengths and weaknesses as a group leader. Identifies problematic issues in group process but requires assistance to handle them. May require assistance organizing group materials.

E Has significant inadequacies in understanding and implementation of group process. Unable to maintain control in group sufficient to cover content areas. Preparation is sometimes disorganized.

R Defensive or lacks insight when discussing strengths and weaknesses. Frequently unprepared for content or with materials.

GOAL: COMPETENCE IN SCHOLARLY INQUIRY AND APPLICATION OF CURRENT SCIENTIFIC KNOWLEDGE TO PRACTICE

OBJECTIVE: SEEKS CURRENT SCIENTIFIC KNOWLEDGE

Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas.

A Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.

HI Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.

I/E Open to learning, but waits for supervisor to provide guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding.

R Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.

OBJECTIVE: DEVELOPS AND IMPLEMENTS RESEARCH PLAN

Develops and implements plan for research or other professional writing or presentation.

N/A Not applicable.
A Develops research plan alone or in conjunction with a colleague. Is a full and equal participant in the project.
HI Provides substantive input into the plan. Demonstrates ability to execute at least one aspect of the project independently.
I/E Provides helpful suggestions regarding design and implementation of a colleague's plan. Provides significant assistance in the accomplishment of the project.
R Does not follow-through with responsibilities in development or implementation of plan.

GOAL: COMPETENCE IN PROFESSIONAL CONSULTATION

OBJECTIVE: CONSULTATION ASSESSMENT

Performs an assessment of the patient referred for consultation, incorporating mental status exam, structured interview techniques or psychological assessment, as needed, to answer the referral question.

N/A Not applicable.
A Chooses appropriate means of assessment to respond effectively to the referral question; reports and progress notes are well-organized and provide useful and relevant recommendations with minimal supervisory input.
HI Occasional input is needed regarding appropriate measures of assessment and effective write-up of report or progress notes to best answer the referral question
I/E Needs continued supervision regarding appropriate assessment techniques to complete consultations as well as input regarding integration of findings and recommendations.
R Consultation reports and progress notes are poorly written and/or organized. Fails to incorporate relevant information and/or use appropriate measures of assessment necessary to answer the referral question.

OBJECTIVE: CONSULTATIVE GUIDANCE

Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.

N/A Not applicable.
A Relates well to those seeking input, is able to provide appropriate feedback.
HI Requires occasional input regarding the manner of delivery or type of feedback given.
I/E Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals.
R Unable to establish rapport.

GOAL: COMPETENCE IN PROVIDING CLINICAL SUPERVISION

OBJECTIVE: SUPERVISORY SKILLS

Demonstrates good knowledge of supervision techniques and employs these skills in a consistent and effective manner, seeking consultation as needed. Builds good rapport with supervisee.

N/A Not applicable.

A Spontaneously and consistently applies supervision skills. Supervisee verbalizes appreciation of trainee's input.

HI Consistently recognizes relevant issues, needs occasional guidance and supervisory input. Well thought of by supervisee. Supervisee recognizes at least one significant strength of trainee as a supervisor as documented on evaluation form.

I/E Generally recognizes relevant issues, needs guidance regarding supervision skills. Supervisee finds input helpful. Trainee is rated by supervisee at the satisfactory or higher level in all areas.

R Unable to provide helpful supervision.

ROTATION-SPECIFIC GOALS AND SKILLS

Please list the major goals of your rotation and rate the intern's performance on meeting them.

1. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

2. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

3. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

4. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

5. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

Please list the skills that your rotation is designed to teach and rate the intern's success at learning and performing them.

1. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

2. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

3. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

4. Skill:

Comments:

Rating: _____ Advanced

_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

5. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

SUPERVISOR COMMENTS

Summary of strengths:

Areas needing additional development or remediation, including recommendations:

Remedial Work Instructions: In the rare situation when it is recognized that a trainee needs remedial work, a competency assessment form should be filled out **immediately**, prior to any deadline date for evaluation, and shared with the trainee and the director of training. In order to allow the trainee to gain competency and meet passing criteria for the rotation, these areas must be addressed proactively and a remedial plan needs to be devised and implemented promptly. One month after a remediation plan is in place, the supervisor will complete a follow-up evaluation with the intern and will provide a copy to the Director of Training. If the minimal threshold for competency is not met at that time, the trainee and supervisor will continue with the remediation plan and subsequent monthly evaluations and reporting to the Director of Training. For VA interns, if the rotation ends before competencies are met, the Director of Training will work with the supervisor for the next rotation to put a training plan in place that addresses areas of weakness identified in the previous rotation.

Goal for intern evaluations done at mid-rotation (VA interns) or mid-year (UM interns): All competency areas will be rated at a level of competence of **I** or higher. No competency areas will be rated as **R** or **E.**

Goal for intern evaluations done at the end of rotation (VA interns) or at the end of the internship year (UM interns): At least 80% of competency areas will be rated at level of competence of **HI** or higher. No competency areas will be rated as **R** or **E**. Note: exceptions would be specialty area rotations that would take a more intensive course of study to achieve this level of competency and the major supervisor, training director and trainee agree that a level of **I** is appropriate for that particular rotation, e.g. a neuropsychology rotation for a comprehensive track trainee.

_____ The trainee HAS successfully completed the above goal for this evaluation period. We have reviewed this evaluation together.

_____ The trainee HAS NOT successfully completed the above goal for this evaluation period. We have made a joint written remedial plan as attached, with specific dates indicated for completion. Once completed, the rotation will be re-evaluated using another evaluation form, or on this form, clearly marked as an updated evaluation. We have reviewed this evaluation together.

Supervisor _____ Date _____

Trainee Comments Regarding Competency Evaluation (if any):

_____

_____

_____

_____

_____

I have received a full explanation of this evaluation. I understand that my signature does not necessarily indicate my agreement.

Trainee _____ Date _____

APPENDIX B

VAMHCS/UMB PSYCHOLOGY INTERNSHIP CONSORTIUM

PSYCHOLOGY TRAINEE COMPETENCY SELF- ASSESSMENT FORM

Trainee: _____ Date: _____

Track: _____

Evaluation Time Point: Beginning of Year: _____ End of Year: _____

Areas of Core Competency:

1. **Professional Conduct, Ethics, and Legal Matters**
2. **Individual and Cultural Diversity**
3. **Theories and Methods of Psychological Diagnosis and Assessment**
4. **Theories and Methods of Psychotherapeutic Intervention**
5. **Scholarly Inquiry and Application of Scientific Knowledge to Practice**
6. **Competence in Professional Consultation**
7. **Providing Clinical Supervision**

COMPETENCY RATINGS DESCRIPTIONS

NA	**Not applicable for this training experience/Not assessed during training experience**
A	**Advanced/Skills comparable to autonomous practice at the licensure level.** This **r**ating is typically expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however as an unlicensed trainee, supervision is required while in training status.
HI	**High intermediate/Occasional supervision needed.** This rating is frequently appropriate for trainees at completion of internship. It indicates that competency has been attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant.
I	**Intermediate/Should remain a focus of supervision.** This is a common rating throughout internship and pre-internship practica. Routine supervision of each activity is needed.
E	**Entry level/Continued intensive supervision is needed.** This is the most common rating for practica-level trainees. Routine, but intensive, supervision is needed.
R	**Needs remedial work**. Requires remedial work if trainee is in internship or post-doctoral training.

GOAL: COMPETENCE IN PROFESSIONAL CONDUCT, ETHICS AND LEGAL MATTERS

OBJECTIVE: PROFESSIONAL INTERPERSONAL BEHAVIOR

Interactions with treatment teams, peers and supervisors are professional and appropriate; Trainee seeks peer support as needed.

A Smooth working relationships, handles differences openly, tactfully and effectively.

HI Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns.

I Progressing well on providing input in a team setting. Effectively seeks assistance to cope with interpersonal concerns with colleagues.

E Ability to participate in team model is limited, relates well to peers and supervisors.

R May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

OBJECTIVE: SEEKS CONSULTATION/SUPERVISION

Seeks consultation or supervision as needed and uses it productively.

A Actively seeks consultation when treating complex cases and working with unfamiliar symptoms.

HI Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain; Occasionally over- or under-estimates need for supervision.

I Generally accepts supervision well, but occasionally defensive. Needs supervisory input for determination of readiness to try new skills.

E Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.

R Frequently defensive and inflexible; Resists important and necessary feedback.

OBJECTIVE: USES POSITIVE COPING STRATEGIES

Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.

A Good awareness of personal and professional problems. Stressors have only mild impact on professional practice. Actively seeks supervision and/or personal therapy to resolve issues.

HI Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact.

I Needs significant supervision time to minimize the effect of stressors on professional functioning. Accepts reassurance from supervisor well.

E Personal problems can significantly disrupt professional functioning.

R Denies problems or otherwise does not allow them to be addressed effectively.

OBJECTIVE: PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION

Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.

A Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.

HI Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.

I Uses supervisory feedback well to improve documentation. Needs regular feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.

E Needs considerable direction from supervisor. May leave out crucial information.

R May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

OBJECTIVE: EFFICIENCY AND TIME MANAGEMENT

Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.

A Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.

HI Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner, but needs occasional deadlines or reminders.

I Completes work effectively and promptly by using supervision time for guidance. Regularly needs deadlines or reminders.

E Highly dependent on reminders or deadlines.

R Frequently has difficulty with timeliness fashion. Or tardiness or unaccounted absences are a problem.

OBJECTIVE: KNOWLEDGE OF ETHICS AND LAW

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

A Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgement is reliable about when consultation is needed

HI Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.

I Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.

E Often unaware of important ethical and legal issues.

R Disregards important supervisory input regarding ethics or law.

OBJECTIVE: ADMINISTRATIVE COMPETENCY

Demonstrates a growing ability to accomplish administrative tasks. Prioritizes appropriately. Shows a growing autonomy in management of larger administrative, research or clinical projects.

A Independently assesses the larger task to be accomplished, breaks the task into smaller ones and develops a timetable. Prioritizes various tasks and deadlines efficiently and without need for supervisory input. Makes adjustments to priorities as demands evolve.

HI Identifies components of the larger task and works independently on them. Needs some supervisory guidance to successfully accomplish large tasks within the timeframe allotted. Identifies priorities but needs input to structure some aspects of task.

I Completes work effectively, using supervision time to identify priorities and develop plans to accomplish tasks. Receptive to supervisory input to develop own skills in administration.

E Trainee takes on responsibility then has difficulty asking for guidance or accomplishing goals within timeframe.

R Deadline passes without task being done. Not receptive to supervisory input about own difficulties in this process.

GOAL: COMPETENCE IN INDIVIDUAL AND CULTURAL DIVERSITY

OBJECTIVE: PATIENT RAPPORT

Consistently achieves a good rapport with patients.

A Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.

HI Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.

I Actively developing skills with new populations. Relates well when has prior experience with the population.

E Has difficulty establishing rapport.

R Alienates patients or shows little ability to recognize problems.

OBJECTIVE: SENSITIVITY TO PATIENT DIVERSITY

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

A Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.

HI In supervision, recognizes and openly discusses limits to competence with diverse clients.

I Has significant lack of knowledge regarding some patient groups, but resolves such issues effectively through supervision. Open to feedback regarding limits of competence.

E Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.

R Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

OBJECTIVE: AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND

Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.

A Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.

HI Aware of own cultural background. Uses supervision well to examine this in psychological work. Readily acknowledges own culturally-based assumptions when these are identified in supervision.

I Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differences that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.

E Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and conceptualizations from culturally-based assumptions. Responds well to supervision.

R Has little insight into own cultural beliefs even after supervision.

GOAL: COMPETENCE IN THEORIES AND METHODS OF PSYCHOLOGICAL DIAGNOSIS AND ASSESSMENT

OBJECTIVE: DIAGNOSTIC SKILL

Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclature and DSM multiaxial classification. Utilizes historical, interview and psychometric data to diagnose accurately.

A Demonstrates a thorough knowledge of psychiatric classification, including multiaxial diagnoses and relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.

HI Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good. Uses supervision well in more complicated cases involving multiple or more unusual diagnoses.

I Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May miss relevant patient data when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.

E/R Has significant deficits in understanding of the psychiatric classification system and/or ability to use DSM-5 criteria to develop a diagnostic conceptualization.

OBJECTIVE: PSYCHOLOGICAL TEST SELECTION AND ADMINISTRATION

Promptly and proficiently administers commonly used tests in his/her area of practice. Appropriately chooses the tests to be administered.

N/A Not applicable.
A Proficiently administers all tests. Completes all testing efficiently. Autonomously chooses appropriate tests to answer referral question.
HI Occasional input needed regarding fine points of test administration. Occasionally needs reassurance that selected tests are appropriate.
I Needs continued supervision on frequently administered tests. Needs occasional consultation regarding appropriate tests to administer.
E/R Test administration is irregular, slow, or often needs to recall patient to further testing sessions due to poor choice of tests administered.

OBJECTIVE: PSYCHOLOGICAL TEST INTERPRETATION

Competently interprets the results of psychological tests used in his/her area of practice.

N/A Not applicable
A Skillfully and efficiently interprets tests autonomously. Makes accurate independent diagnostic formulations on a variety of syndromes. Accurately interprets and integrates results prior to supervision session.
HI Demonstrates knowledge of scoring methods, reaches appropriate conclusions with some support from supervision.
I Completes assessments on typical patients with some supervisory input, occasionally uncertain how to handle difficult patients or unusual findings. Understands basic use of tests, may occasionally reach inaccurate conclusions or take computer interpretation packages too literally.
E/R Significant deficits in understanding of psychological testing, over-reliance on computer interpretation packages for interpretation. Repeatedly omits significant issues from assessments, reaches inaccurate or insupportable conclusions.

OBJECTIVE: ASSESSMENT WRITING SKILLS

Writes a well-organized psychological report. Answers the referral question clearly and provides the referral source with specific recommendations.

N/A Not applicable
A Report is clear and thorough, follows a coherent outline, and is an effective summary of major relevant issues. Relevant test results are woven into the report as supportive evidence. Recommendations are related to referral questions.
HI Report covers essential points without serious error, may need polish in cohesiveness and organization. Readily completes assessments with minimal supervisory input, makes useful and relevant recommendations.
I Uses supervision effectively for assistance in determining important points to highlight.
E/R Inaccurate conclusions or grammar interfere with communication or reports are poorly organized and require major rewrites.

OBJECTIVE: FEEDBACK REGARDING ASSESSMENT

Plans and carries out a feedback interview. Explains the test results in terms the patient and/or caregiver can understand, provides suitable recommendations and responds to issues raised by patient or caregiver.

N/A Not applicable

A Plans and implements the feedback session appropriately. Foresees areas of difficulty in the session and responds empathically to patient or caregiver concerns. Adjusts personal style and complexity of language and feedback details to accommodate patient or caregiver needs.

HI With input from supervisor, develops and implements a plan for the feedback session. May need some assistance to identify issues which may become problematic in the feedback session. May need intervention from supervisor to accommodate specific needs of patient or family.

I Develops plan for feedback session with the supervisor. Presents basic assessment results and supervisor addresses more complex issues. Continues to benefit from feedback on strengths and areas for improvement.

E Supervisor frequently needs to assume leadership in feedback sessions to ensure correct feedback is given or to address emotional issues of patient or caregiver.

R Does not modify interpersonal style in response to feedback.

GOAL: COMPETENCE IN THEORIES AND METHODS OF EFFECTIVE PSYCHOTHERAPEUTIC INTERVENTION

OBJECTIVE: PATIENT RISK MANAGEMENT AND CONFIDENTIALITY

Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.

A Assesses and documents all risk situations fully prior to leaving the worksite for the day. Appropriate actions taken to manage patient risk situations (e.g. escorting patient to ER) are initiated immediately, then consultation and confirmation of supervisor is sought. Establishes appropriate short-term crisis plans with patients.

HI Aware of how to cope with safety issues, continues to need occasional reassurance in supervision. Asks for input regarding documentation of risk as needed. Sometimes can initiate appropriate actions to manage patient risk, sometimes needs input of supervisor first. May occasionally forget to discuss confidentiality issues promptly.

I Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards trainee handles them well. Can be trusted to seek consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. Needs input regarding documentation of risk. Occasionally needs prompting to discuss confidentiality issues with patient.

E Delays or forgets to ask about important safety issues. Does not document risk appropriately but does not let patient leave site without seeking "spot" supervision for the crisis. Does not remember to address confidentiality issues, needs frequent prompting. Fear may overwhelm abilities in patient crises.

R Makes inadequate assessment or plan, then lets patient leave site before consulting supervisor.

OBJECTIVE: CASE CONCEPTUALIZATION AND TREATMENT GOALS

Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.

A Independently produces good case conceptualizations within own preferred theoretical orientation, can also draw some insights into case from other orientations. Consistently sets realistic goals with patients.

HI Reaches case conceptualization on own, recognizes improvements when pointed out by supervisor. Readily identifies emotional issues but sometimes needs supervision for clarification. Sets appropriate goals with occasional prompting from supervisor, distinguishes realistic and unrealistic goals.

I Reaches case conceptualization with supervisory assistance. Aware of emotional issues when they are clearly stated by the patient, needs supervision for development of awareness of underlying issues. Requires ongoing supervision to set therapeutic goals aside from those presented by patient.

E/R Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives important emotional issues. Unable to set appropriate treatment goals with patient.

OBJECTIVE: THERAPEUTIC INTERVENTIONS

Interventions are well-timed, effective and consistent with empirically supported treatments.

A Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed.

HI Most interventions and interpretations facilitate patient acceptance and change. Supervisory assistance needed for timing and delivery of more difficult interventions.

I Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.

E/R Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation.

OBJECTIVE: EFFECTIVE USE OF EMOTIONAL REACTIONS IN THERAPY (COUNTERTRANSFERENCE)

Understands and uses own emotional reactions to the patient productively in the treatment.

A During session, uses countertransference to formulate hypotheses about patient's current and historical social interactions, presents appropriate interpretations and interventions. Able to identify own issues that impact the therapeutic process and has ideas for coping with them. Seeks consultation as needed for complex cases.

HI Uses countertransference to formulate hypotheses about the patient during supervision sessions. Can identify own issues that impact therapeutic process. Interventions generally presented in the following session.

I Understands basic concepts of countertransference. Can identify own emotional reactions to patient as countertransference. Supervisory input is frequently needed to process the information gained.

E When feeling anger, frustration or other intense emotional response to the patient, blames patient at times. Welcomes supervisory input and can reframe own emotional response to the session.

R Unable to see countertransference issues, even with supervisory input.

OBJECTIVE: GROUP THERAPY SKILLS AND PREPARATION

Intervenes in group skillfully, attends to member participation, completion of therapeutic assignments, group communication, safety and confidentiality. If the group is psychoeducational, readies materials for group, and understands each session's goals and tasks.

A Elicits participation and cooperation from all members, confronts group problems appropriately and independently, and independently prepares for each session with little or no prompting. Can manage group alone in absence of cotherapist/supervisor with follow-up supervision later.

HI Seeks input on group process issues as needed, then works to apply new knowledge and skills. Needs occasional feedback concerning strengths and weaknesses. Generally prepared for group sessions.

I Welcomes ongoing supervision to identify key issues and initiate group interaction. Actively working on identifying own strengths and weaknesses as a group leader. Identifies problematic issues in group process but requires assistance to handle them. May require assistance organizing group materials.

E Has significant inadequacies in understanding and implementation of group process. Unable to maintain control in group sufficient to cover content areas. Preparation is sometimes disorganized.

R Defensive or lacks insight when discussing strengths and weaknesses. Frequently unprepared for content or with materials.

GOAL: COMPETENCE IN SCHOLARLY INQUIRY AND APPLICATION OF CURRENT SCIENTIFIC KNOWLEDGE TO PRACTICE

OBJECTIVE: SEEKS CURRENT SCIENTIFIC KNOWLEDGE

Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas.

A Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.

HI Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.

I/E Open to learning, but waits for supervisor to provide guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding.

R Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.

OBJECTIVE: DEVELOPS AND IMPLEMENTS RESEARCH PLAN

Develops and implements plan for research or other professional writing or presentation.

N/A Not applicable.
A Develops research plan alone or in conjunction with a colleague. Is a full and equal participant in the project.
HI Provides substantive input into the plan. Demonstrates ability to execute at least one aspect of the project independently.
I/E Provides helpful suggestions regarding design and implementation of a colleague's plan. Provides significant assistance in the accomplishment of the project.
R Does not follow-through with responsibilities in development or implementation of plan.

GOAL: COMPETENCE IN PROFESSIONAL CONSULTATION

OBJECTIVE: CONSULTATION ASSESSMENT

Performs an assessment of the patient referred for consultation, incorporating mental status exam, structured interview techniques or psychological assessment, as needed, to answer the referral question.

N/A Not applicable.
A Chooses appropriate means of assessment to respond effectively to the referral question; reports and progress notes are well-organized and provide useful and relevant recommendations with minimal supervisory input.
HI Occasional input is needed regarding appropriate measures of assessment and effective write-up of report or progress notes to best answer the referral question
I/E Needs continued supervision regarding appropriate assessment techniques to complete consultations as well as input regarding integration of findings and recommendations.
R Consultation reports and progress notes are poorly written and/or organized. Fails to incorporate relevant information and/or use appropriate measures of assessment necessary to answer the referral question.

OBJECTIVE: CONSULTATIVE GUIDANCE

Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.

N/A Not applicable.
A Relates well to those seeking input, is able to provide appropriate feedback.
HI Requires occasional input regarding the manner of delivery or type of feedback given.
I/E Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals.
R Unable to establish rapport.

GOAL: COMPETENCE IN PROVIDING CLINICAL SUPERVISION

OBJECTIVE: SUPERVISORY SKILLS

Demonstrates good knowledge of supervision techniques and employs these skills in a consistent and effective manner, seeking consultation as needed. Builds good rapport with supervisee.

N/A Not applicable.

A Spontaneously and consistently applies supervision skills. Supervisee verbalizes appreciation of trainee's input.

HI Consistently recognizes relevant issues, needs occasional guidance and supervisory input. Well thought of by supervisee. Supervisee recognizes at least one significant strength of trainee as a supervisor as documented on evaluation form.

I/E Generally recognizes relevant issues, needs guidance regarding supervision skills. Supervisee finds input helpful. Trainee is rated by supervisee at the satisfactory or higher level in all areas.

R Unable to provide helpful supervision.

TRAINEE-SPECIFIC GOALS AND SKILLS

Please list the major goals you would like to work toward this training year.

1. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

2. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

3. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

4. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

5. Goal:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

Please list the specific skills you would like to develop this training year.

1. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

2. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

3. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

4. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

5. Skill:

Comments:

Rating: _____ Advanced
_____ High intermediate
_____ Intermediate
_____ Entry level
_____ Needs remedial work

Summary of strengths:

Areas needing additional development:

Trainee: _____ Date _____

Training Program Director comments:

_____ Date _____
Psychology Training Program Director

APPENDIX C

VAMHCS/UMB Psychology Internship Consortium
Supervisor Feedback Form

Intern name: _____ **Supervisor name:** _____

Rotation/Clinic: _____

Evaluation time point: UM interns: First mid-year (Oct.)
Second mid-year (Feb.)
Final

VA interns:

1st rotation	mid	final
2nd rotation	mid	final
3rd rotation	mid	final

Please use the Likert scale below to rate the supervision you received on this rotation.

Very Ineffective	Not Effective	Somewhat Effective	Effective	Very Effective	Not Applicable
1	**2**	**3**	**4**	**5**	**N/A**

Supervisory Responsibilities

The supervisor was at supervisory meetings promptly and reliably.
1 2 3 4 5 N/A

The supervisor was available for "spot supervision."
1 2 3 4 5 N/A

The supervisor educated me fully about documentation and confidentiality issues.
1 2 3 4 5 N/A

The supervisor clarified roles, process of supervision and a plan to meet my training needs at the start of the rotation.
1 2 3 4 5 N/A

Comments:

Supervisory Content

The supervisor discussed ethical issues pertaining to patient care.
1 2 3 4 5 N/A

The supervisor discussed diversity issues related to my training experience.
1 2 3 4 5 N/A

The supervisor educated me about coping with risk issues such as suicidality and homicidality in therapy, including assessment, documentation, contracting and addressing the issue therapeutically.
1 2 3 4 5 N/A

The supervisor provided didactic material (i.e., readings, trainings) that was effective in expanding my knowledge base in the field and/or the specialty area he/she provides supervision in.

1 2 3 4 5 N/A

The supervisor shared case material and therapeutic difficulties relating to the supervisor's own patients with me.
1 2 3 4 5 N/A

If you answered yes to the preceding question, was this process effective and helpful in supervision?
1 2 3 4 5 N/A

Audiotapes were utilized in supervision.
____ No
____ Yes

The supervisor made in vivo observations of my work (can include observation of testing, joint bedside consultations, and co-leading groups).
____ No
____ Yes

Comments:

Supervisory Process

The supervisor fostered good communication, respect and trust.
1 2 3 4 5 N/A

We discussed difficulties in the supervisory relationship.
1 2 3 4 5 N/A

I felt comfortable with how the supervisor gave me feedback on my work.
1 2 3 4 5 N/A

The supervisor fostered an environment that made me feel comfortable discussing counter transference issues.
1 2 3 4 5 N/A

The supervisor concentrated on my training needs during supervision and was interested in my growth as a clinician.
1 2 3 4 5 N/A

Comments:

Assistance in Professional Development

The supervisor facilitated the process of me becoming a valuable member of the treatment team.
1 2 3 4 5 N/A

In group therapy, the supervisor was an effective role model for me.
1 2 3 4 5 N/A

The supervisor was flexible about my duties as needed for my professional growth, while consulting about time management as appropriate.
1 2 3 4 5 N/A

The supervisor encouraged positive professional relationships with colleagues through role-modeling and discussion.
1 2 3 4 5 N/A

The supervisor encouraged me in greater autonomy, as my capabilities and skills allowed.

1 2 3 4 5 N/A

As appropriate, we discussed how to minimize the impact of anxiety and stressors on professional functioning.

1 2 3 4 5 N/A

As needed, we discussed the development of my professional identity as a psychologist.

1 2 3 4 5 N/A

Comments:

Assistance in Development as Scientist-Practitioner

The supervisor was knowledgeable about the literature and research in the appropriate specialty areas, discussing research finding and professional writings that pertained to cases.

1 2 3 4 5 N/A

The supervisor suggested specific professional reading and/or encouraged me to seek out professional literature as needed.

1 2 3 4 5 N/A

The supervisor provided guidance in the flexible administration of empirically supported treatments, based on the client's presenting problems.

1 2 3 4 5 N/A

Comments:

Assistance in Meeting Training Goals

Please Note: This section provides you and your supervisor the opportunity to review the training goals set forth at the beginning of the rotation/year. Your supervisor has the opportunity to evaluate your progress on these goals on your evaluation form, and you have the opportunity to evaluate their effectiveness in teaching/supervision of those skills here. Please use the Psychology Trainee Competency Assessment Form to fill in your training goals for the rotation below.

The supervisor demonstrated developmentally appropriate and constructive feedback in teaching/supervision of the application of _____ (treatment modality/skill), which is the core focus of this rotation.

1 2 3 4 5 N/A

The supervisor demonstrated developmentally appropriate and constructive feedback in teaching/supervision of the application of _____ (treatment modality/skill), which is the core focus of this rotation.

1 2 3 4 5 N/A

The supervisor demonstrated developmentally appropriate and constructive feedback in teaching/supervision of the application of _____ (treatment modality/skill), which is the core focus of this rotation.

1 2 3 4 5 N/A

Comments:

Summary Ratings

The supervisor fulfilled his/her supervisory responsibilities.

1 2 3 4 5 N/A

The supervisory content was effective in meeting my training needs for the rotation.

1 **2** **3** **4** **5** **N/A**

The supervisor addressed diversity issues adequately in supervision.

1 **2** **3** **4** **5** **N/A**

The supervisory process was open, directive and facilitated my development as a training psychologist.

1 **2** **3** **4** **5** **N/A**

The supervisor provided adequate assistance in my development as a scientist-practitioner.

1 **2** **3** **4** **5** **N/A**

The supervisor showed interest and provided adequate assistance in my professional development.

1 **2** **3** **4** **5** **N/A**

Comments

Suggestions:

Summary of Strengths:

We have reviewed the above evaluation together.

Intern _____ Date _____

Supervisor_____ Date _____

APPENDIX D

2015-2016

VAMHCS/UMB INTERNSHIP EVALUATION FORM

Rotation-specific Questions

Please complete one copy for each rotation including minor rotations.

Rotation name:

1) What were the BEST aspects of this rotation? What did you like the most? What did you learn the most from?

2) What were the WORST aspects of this rotation? What did you find least helpful or most problematic? What changes would you recommend for the rotation?

3) How was the supervision on this rotation? What did you find most helpful/supportive? What would you have changed about it?

General Questions

Please give an overall rating of the internship program:

1	2	3	4	5	6	7	8	9	10
Very poor									Excellent

1) What were your favorite aspects of the internship? Where, or from what, did you learn the most? What experiences did you find most relevant and/or rewarding? What were the STRONGEST aspects of the internship?

2) What aspects of the internship did you like the least or find least rewarding? What were the WEAKEST aspects of the internship? What changes would you recommend for the internship?

3) If a prospective applicant asked you about this internship, what would you tell them were the reasons they should apply? What reasons would you give that they shouldn't apply?

Didactics Questions

**** If your track provided additional didactics specific to your specialty, you may provide feedback for those seminars here as well.**

1) Were there any topics that we did NOT cover that you would have liked to have seen?

2) What do you think about the balance of internal (i.e., VA and School of Medicine faculty/staff) and external speakers?

3) Do you have any suggestions or comments about the way the seminars are organized or scheduled?

Research Requirement Questions

1) Did you think the research requirement was a beneficial aspect of the internship?

2) How satisfied were you with the overall quality of the research project you produced? How did you feel about the overall quality of the research presented by your peers?

3) How was the supervision/guidance on the research project? What would you have changed about it?

Overall Comments

Feel free to express anything you feel is important that was not covered by the previous pages.